

CERTIFICATE OF DEATH

00104

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Alleghany ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel				c. LENGTH OF STAY IN 1b 1 month			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				d. STREET ADDRESS Route #2, Williams Rd.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Brock Bridge Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ella Middle Mae Last Ammons				4. DATE OF DEATH Month January Day 20 Year 19 60			
5. SEX Female		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 10, 1934	
9. AGE (In years last birthday) 25 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Maryland		11. BIRTHPLACE (State or foreign country) USA	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Matthew Dolly				14. MOTHER'S MAIDEN NAME Edna Ash			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. none		17. INFORMANT Robert Ammons, husband. Address Same address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 434.1 Congestive heart failure DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatic fever							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----							
20c. TIME OF INJURY Hour a. m. _____ p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from 1/13, 1960 , to 1/20, 1960 , that I last saw the deceased alive on 1/13, 1960 and that death occurred at 7:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 402 Main St., Laurel, Md. DATE SIGNED 1/20/60							
ACTUAL SIGNATURE John R. Buell M.D.							
PHYSICIAN'S NAME (Type) John R. Buell M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 23, 1960		22c. NAME OF CEMETERY OR CREMATORY Mt. Herman Cemetery		22d. LOCATION (City, town, or county) (State) Alleghany County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR DATE JAN 25 '60		24b. REGISTRAR'S SIGNATURE <i>Charles E. Hafer</i>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0106 CERTIFICATE OF DEATH

Reg. Dist. No.

00105

1. PLACE OF DEATH a. COUNTY <u>aa</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>aa</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION) <u>St. A. General</u>		d. STREET ADDRESS <u>1107 Spa View Ave</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Adam Kahler Backer</u>		4. DATE OF DEATH Month Day Year <u>1 - 24 1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 14 - 1893</u>
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Battery Electric</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John William Backer</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Weaver Kahler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give year or dates of service) <u>World War I</u>		16. SOCIAL SECURITY NO. <u>212-05-6407</u>	
17. INFORMANT <u>Elisabeth S Backer</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac disease</u> 4344 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ (b) _____ (c) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov 8, 1958</u> to <u>JAN 24, 1960</u> , that I last saw the deceased alive on <u>JAN 24, 1960</u> , and that death occurred at <u>P. M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>1/24/60</u>	
PHYSICIAN'S NAME (Type) <u>E. L. Uhland</u>		ADDRESS (Street, city or town, state) <u>Annapolis Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-27-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>		ADDRESS <u>Annapolis Md</u>	
24a. REC'D BY REGISTRAR <u>[Signature]</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	
DATE <u>JAN 28 '60</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

[Faint, mostly illegible handwritten text on a standard death certificate form. The form includes fields for name, age, sex, date of death, cause of death, and place of death. The handwriting is very light and difficult to decipher.]

[Vertical text on the right margin, likely a filing or processing stamp, also mostly illegible.]

0107 CERTIFICATE OF DEATH

Reg. Dist. No.

00106

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>8 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Daisy</u> Middle <u>P</u> Last <u>BALDWIN</u>				4. DATE OF DEATH Month <u>January</u> Day <u>2</u> Year <u>19 60</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>September 4, 1889</u>	
9. AGE (In years lost birthday) <u>70</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>George Pascal</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>550 32 0662</u>		17. INFORMANT <u>Hospital Records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROSIS GEN.</u> DUE TO (c) <u>UNKNOWN</u>						INTERVAL BETWEEN ONSET AND DEATH <u>8 DAYS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 25, 1959</u> , to <u>Jan. 2, 1960</u> , that I last saw the deceased alive on <u>Jan. 2, 1960</u> , and that death occurred at <u>3:55 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward S. Beck</u> M.D.				ADDRESS (Street, city or town, state) <u>41 Southgate Ave., 1/4/60</u>			
PHYSICIAN'S NAME (Type) <u>Edward S. Beck</u>				Annepolis, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal-Burial Jan. 6, 1960</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>		ADDRESS <u>Annapolis, Maryland</u>		24a. REC'D BY REGISTRAR <u>JAN 7 60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

00106

STATE OF TEXAS

1910

John Smith

John Smith

John Smith

John Smith

John Smith

John Smith

John Smith

John Smith

John Smith

John Smith

John Smith

John Smith

John Smith

John Smith

John Smith

John Smith

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John Smith

0145 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 60 Glen Burnie	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 544 Munroe Circle		d. STREET ADDRESS 1 544 Munroe Circle	
3. NAME OF DECEASED (Type or print) First Beatrice Middle Irene Last Bartels		4. DATE OF DEATH Month Jan. Day 31 , Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 11, 1900
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles Bart Campbell	
14. MOTHER'S MAIDEN NAME Emma Zellner		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) -----	
16. SOCIAL SECURITY NO. -----		INFORMANT Address Mrs Harry Guinn, Same as 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from August , 19 57 , to 1/31 , 1960, that I last saw the deceased alive on 1/27 , 19 60 , and that death occurred at 9: a M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 1-51-60			
ACTUAL SIGNATURE C. R. MacDonald M.D. M.D.		PHYSICIAN'S NAME (Type) C. R. MacDonald, M.D. 204 Crain Hwy. SW, Glen Burnie	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/3/60	22c. NAME OF CEMETERY OR CREMATORY Locust Wood Memorial	22d. LOCATION (City, town, or county) (State) Delaware Twp. New Jersey
23. FUNERAL DIRECTOR'S SIGNATURE Hopping and Kirkley, Glen Burnie, Md.		24a. REC'D BY REGISTRAR DATE FEB 2 '60	24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

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0108 CERTIFICATE OF DEATH

Reg. Dist. No.

00108

1. PLACE OF DEATH a. COUNTY <i>AA</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>AA</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>47 Southgate Ave</i>		d. STREET ADDRESS <i>147 Southgate Ave</i>	
3. NAME OF DECEASED (Type or print) <i>Archie E. Barton</i>		4. DATE OF DEATH Month <i>1</i> - Day <i>31</i> - Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov 18th 1859</i>
9. AGE (In years last birthday) <i>100</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Annapolis Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i>	
13. FATHER'S NAME <i>William E. Brooks</i>		14. MOTHER'S MAIDEN NAME <i>Lillian Mace</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Mrs. Albert C. Leffler</i>		Address <i>(2)</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardio Vascular Failure</i> <i>422.2</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Pulmonary Congestion</i> DUE TO (c) <i>Myocarditis</i>			INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>2 days</i> <i>Many months</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>9-24</i> , 19 <i>59</i> , to <i>1-31</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>1-31</i> , 19 <i>60</i> , and that death occurred at <i>11:50 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. Oliver Purvis</i>		ADDRESS (Street, city or town, state) <i>40 Frank Ave St. Annapolis Md</i>	
DATE SIGNED <i>2-1-60</i>			
PHYSICIAN'S NAME (Type) <i>J. OLIVER PURVIS</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>2-3-1960</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Bluff Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor</i>		ADDRESS <i>40 Frank Ave St. Annapolis Md</i>	
24a. REC'D BY REGISTRAR <i>4</i>		24b. REGISTRAR'S SIGNATURE <i>John M. Taylor</i>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral-director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

001008

CERTIFICATE OF DEATH

Age 65

DECEASED

DATE

TIME

PLACE

CAUSE

MANNER

SEX

RACE

RELIGION

EDUCATION

OCCUPATION

RESIDENCE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

0109 CERTIFICATE OF DEATH

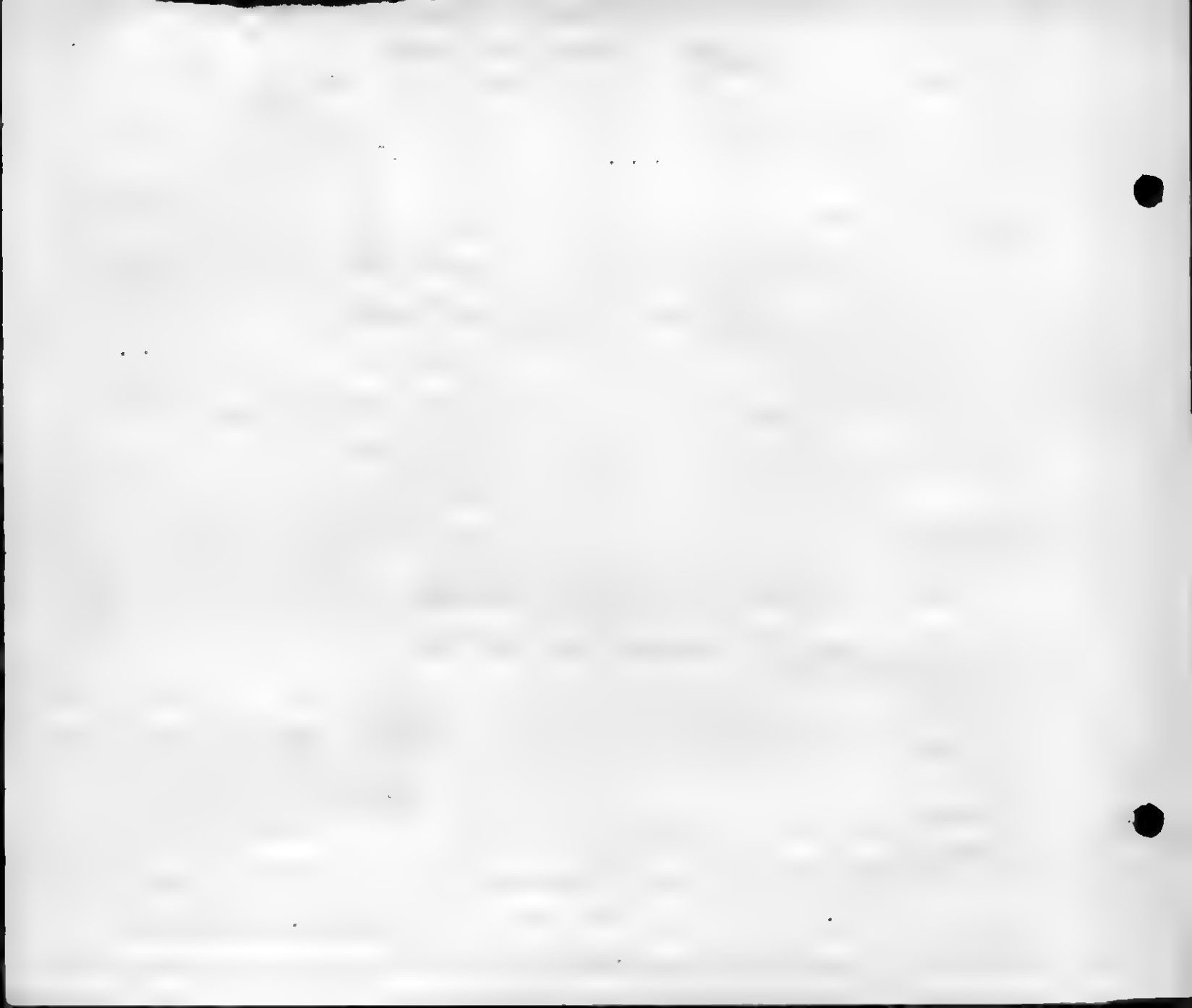
Reg. Dist. No.

00109

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>D.O.A.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Leroy</u> Last <u>BEALL</u>				4. DATE OF DEATH Month <u>January</u> Day <u>13</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 25, 1904</u>		9. AGE (In years last birthday) <u>55</u> yrs.	IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Building construction</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>John Phillip Beall</u>				14. MOTHER'S MAIDEN NAME <u>Lillie Hardy Beall</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214 05 0916</u>		17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>1/13</u> 19 <u>60</u> , to <u>1/13</u> 19 <u>60</u> that I last saw the deceased alive on <u>1/13</u> 19 <u>60</u> and that death occurred at <u>6:50 P.</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Richard N. Peeler</u> M.D.				ADDRESS (Street, city or town, state) <u>121 CATHEDRAL ST ANNAPOLIS, MD</u>			
DATE SIGNED <u>1/13/60</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Jan. 16, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>				ADDRESS <u>Annapolis, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 18 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

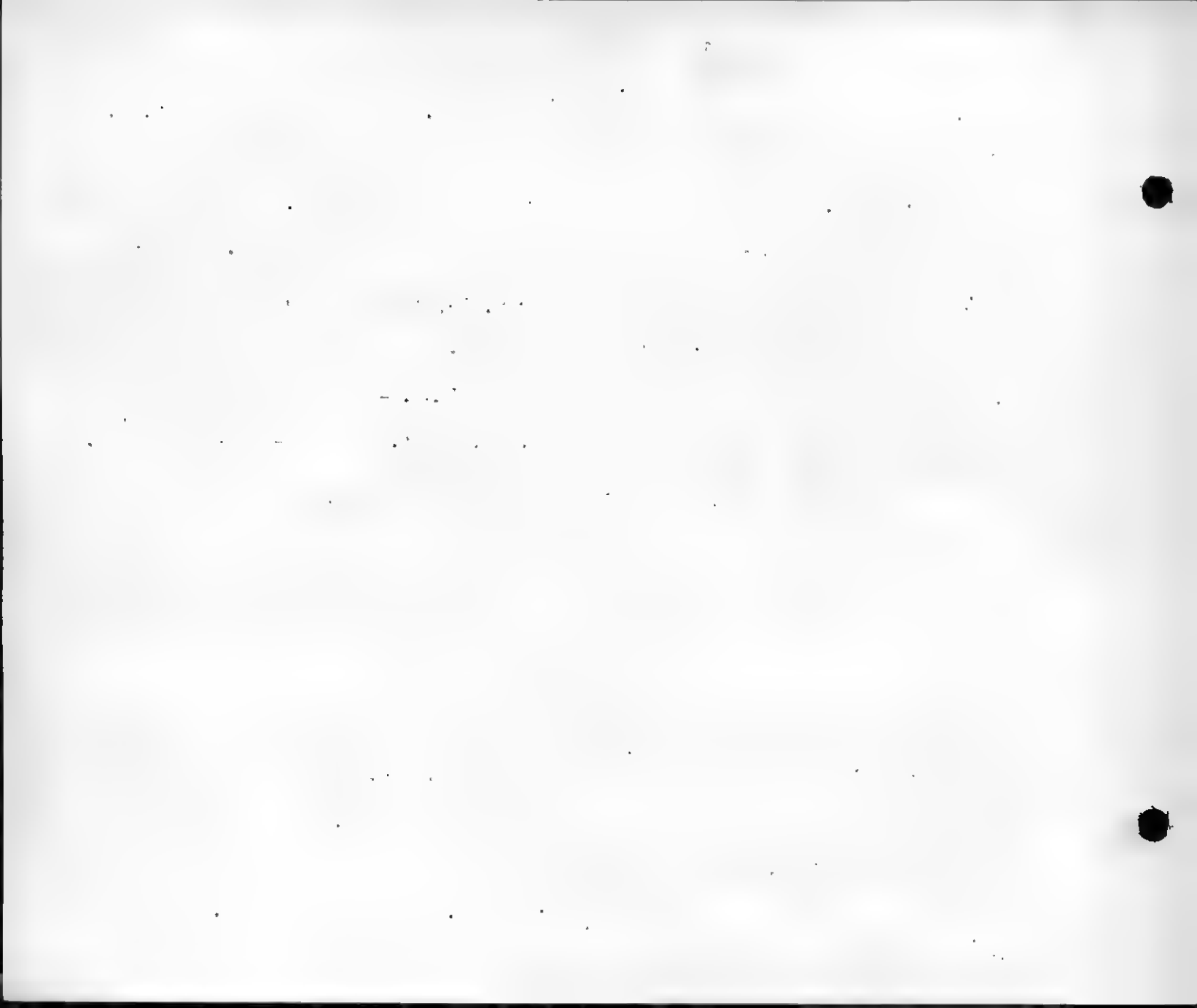
00110

0146

1. PLACE OF DEATH a. COUNTY A. A.				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY A. A.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ferndale				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ferndale			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 19 Eugenia Ave.				e. STREET ADDRESS 19 Eugenia Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RUDOLPH Middle BERNARD Last BERNARD				4. DATE OF DEATH Month Jan. Day 9 Year 1960			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 14, 1887	9. AGE (In years last birthday) 72 yrs.	10. IF UNDER 1 YEAR Months 72 Days 72 Hours 72 Min.		11. IF UNDER 24 HRS. Months 72 Days 72 Hours 72 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter				10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U. S.				13. FATHER'S NAME Robert Bernard			
14. MOTHER'S MAIDEN NAME Anna. - unknown				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. no				17. INFORMANT Mrs. Lillian I. Bernard - 19 Eugenia Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardio vascular diseases DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 4 years (c) 4 years							INTERVAL BETWEEN ONSET AND DEATH 4 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from June 1, 1955 , to January 9, 1960 , that I last saw the deceased alive on 1/8/60 , at 19 , and that death occurred at 2:10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Glen Burnie, Md. DATE SIGNED Glen Burnie, Md.							
ACTUAL SIGNATURE Glen Burnie, Md. M.D. Glen Burnie, Md.							
PHYSICIAN'S NAME (Type) Gustave H. Faubert, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/12/60		22c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.		22d. LOCATION (City, town, or county) (State) Woodlawn, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Lickner & Sons - Baltimore				24a. REC'D BY REGISTRAR DATE JAN 12 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00111

0110

1. PLACE OF DEATH a. COUNTY <u>ANNAPOLIS</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>ANNAPOLIS</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNAPOLIS</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edward</u> <u>Blackston</u> <u>1st</u>				4. DATE OF DEATH Month Day Year <u>1-1</u> <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-18-1897</u>	9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Latent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>A.A.C. Md.</u>		11. BIRTHPLACE (State or foreign country) <u>A.A.C. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Blackston</u>				14. MOTHER'S MAIDEN NAME <u>Anna</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-25 3226 A</u>		17. INFORMANT <u>Anna Blackston</u> Address <u>110 - Clay Street</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolus</u> DUE TO <u>Chronic Arteriosclerosis (Senile)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>30 days</u> DUE TO (c) <u>30 days</u>						INTERVAL BETWEEN ONSET AND DEATH <u>30 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Dec 1</u> , 19 <u>59</u> to <u>Jan 1</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Jan 1</u> , 19 <u>60</u> , and that death occurred at <u>9:15</u> P.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>110 - CLAY STREET</u>				DATE SIGNED <u>1/4/60</u>			
PHYSICIAN'S NAME (Type) <u>ANNAPOLIS, MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>1-5-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ann Arbor</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>[Address]</u>				24a. REC'D BY REGISTRAR <u>[Signature]</u> DATE <u>JAN 8 '60</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



CERTIFICATE OF DEATH

Reg. Dist. No.

00112

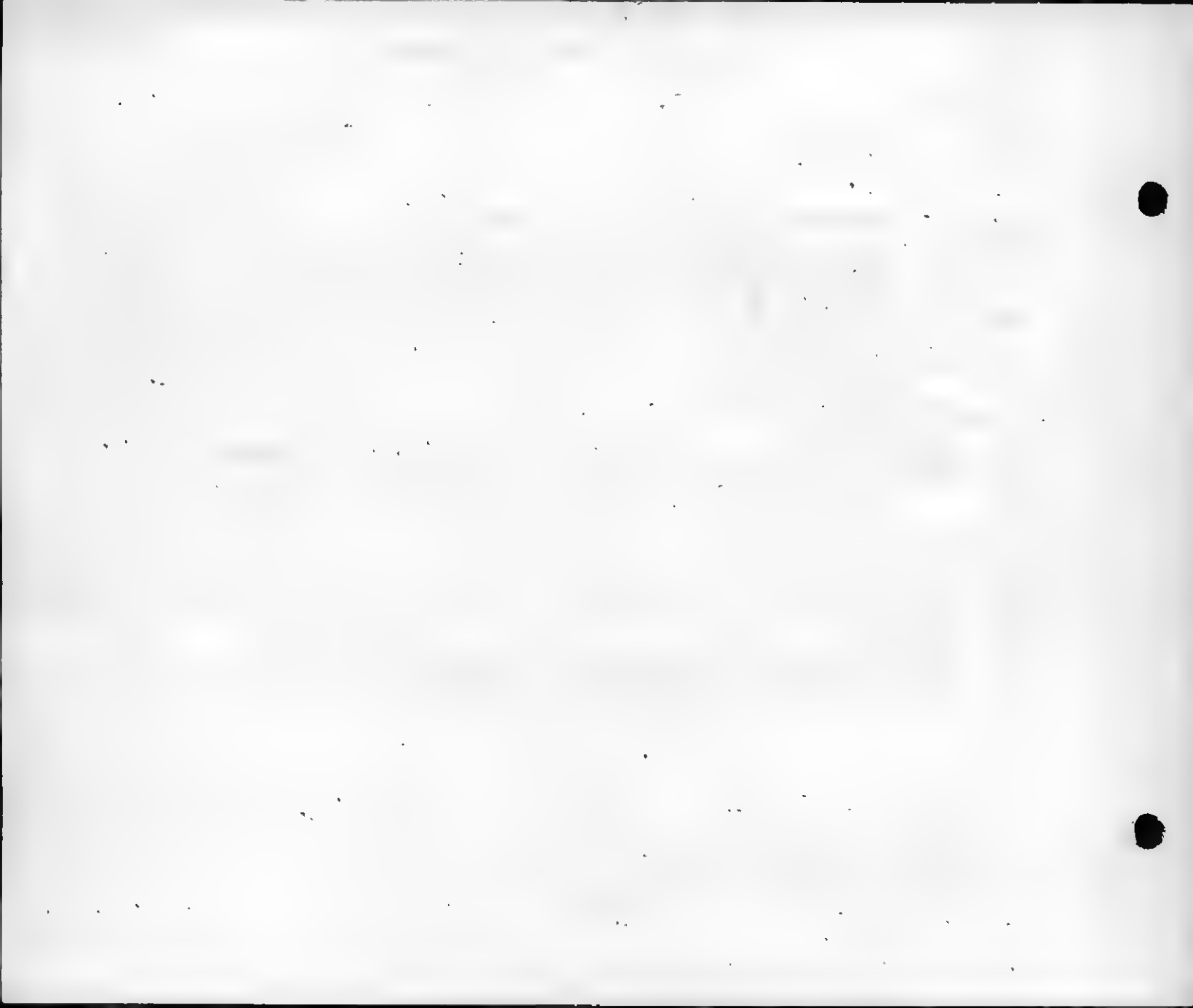
0111

1. PLACE OF DEATH a. COUNTY <u>Adel. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Adel. County</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>Annapolis</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>914 Central Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Richard H. Boardley</u>		4. DATE OF DEATH Month <u>1</u> Day <u>30</u> Year <u>1960</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-20-1874</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>8</u> Days <u>5</u> Hours <u>0</u> Min. <u>0</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>John Boardley</u>		14. MOTHER'S MAIDEN NAME <u>Francis Lacle</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-05-1396A</u>		
17. INFORMANT <u>Heleen Rawlings</u>		Address <u>914 Central St.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>434.1</u> DUE TO <u>Cerebral Cardiovascular Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> DUE TO <u> </u>			INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>12-1-58</u> 19 <u> </u> to <u>1-30-60</u> 19 <u> </u> , that I last saw the deceased alive on <u>1-28-60</u> 19 <u> </u> , and that death occurred at <u>5:47</u> M, from the causes and on the date stated above.				
ACTUAL SIGNATURE <u>A T Allen</u> M D		DATE SIGNED <u>1-1-60</u>		
PHYSICIAN'S NAME (Type) <u>A T ALLEN</u>		ADDRESS (Street, city or town, state) <u>61 Chatham St Annapolis Md</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-2-1960</u>		
22c. NAME OF CEMETERY OR CREMATORY <u>Harwoodville</u>		22d. LOCATION (City, town, or county) (State) <u>Harwoodville Md</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Keesett</u> ADDRESS <u>Annapolis Md</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 3 '60</u>		
		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Hume</u>		

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



0112 CERTIFICATE OF DEATH

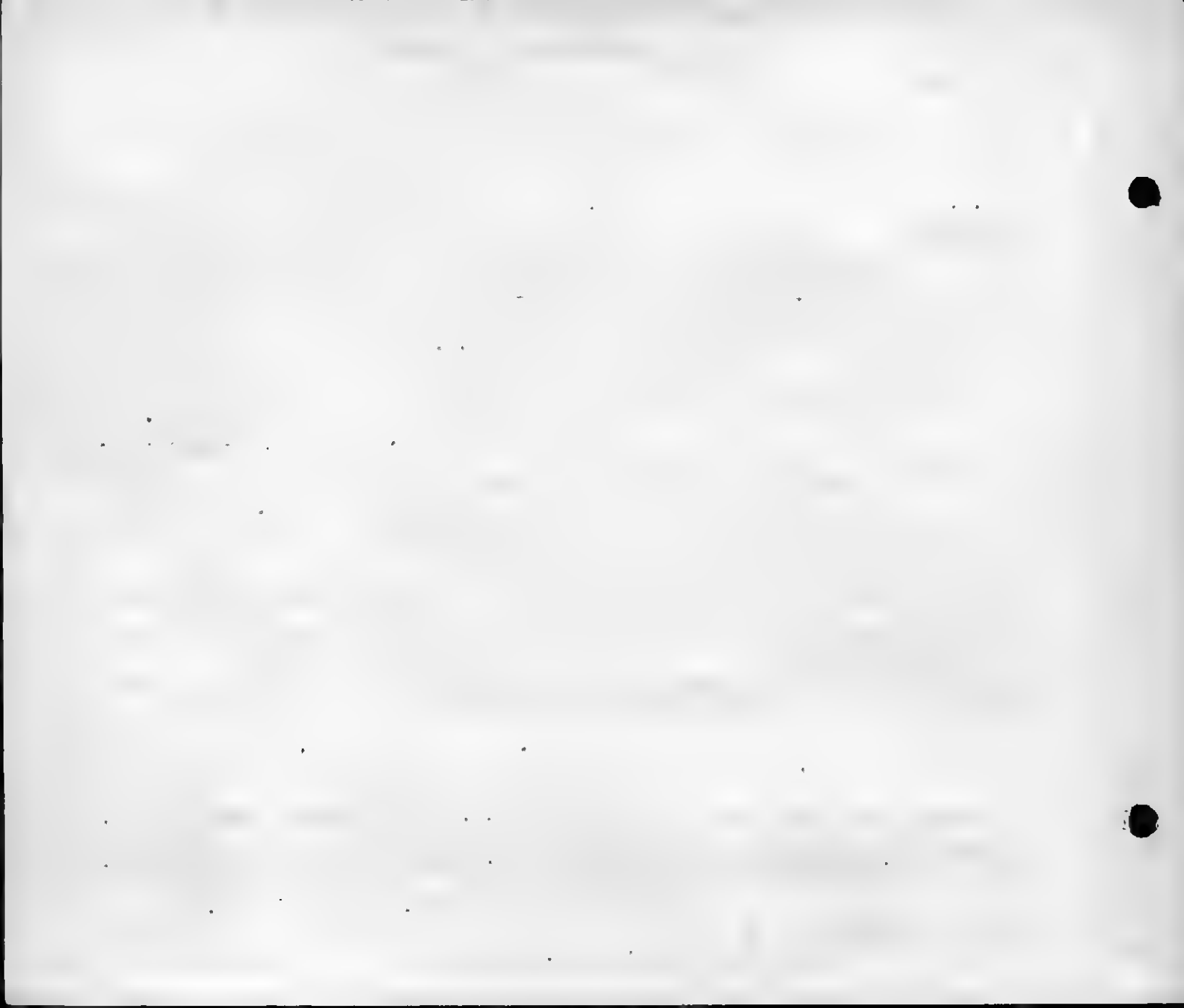
00113

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS				c. LENGTH OF STAY IN 1b 33 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.				d. STREET ADDRESS 5 Revell Street			
3. NAME OF DECEASED (Type or print) First Eise Middle (n) Last BROOKS				4. DATE OF DEATH Month 1 Day 1 Year 1960			
5. SEX M		6. COLOR OR RACE Cauc.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-22-86	
9. AGE (In years lost birthday) 73 yrs.		IF UNDER 1 YEAR: Months 1 Days 1 Hours 1 Min.		IF UNDER 24 HRS: Months 1 Days 1 Hours 1 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. NAVY				10b. KIND OF BUSINESS OR INDUSTRY MILITARY		11. BIRTHPLACE (State or foreign country) N.Y.	
12. CITIZEN OF WHAT COUNTRY? US							
13. FATHER'S NAME Frank BROOKS				14. MOTHER'S MAIDEN NAME Lillian WILDER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW II				16. SOCIAL SECURITY NO. ----		17. INFORMANT Wife: Lillian M. Brooks	
Address 5 Revell Street, Annapolis, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia INTERVAL BETWEEN ONSET AND DEATH 3 days 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinomatosis 3 Months DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 0800 1 Jan., 1960 , to 2030 1 Jan., 1960 , that I last saw the deceased alive on 1900 1 Jan., 1960 , and that death occurred at 8:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE I. Mazzarella				M.D. U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.			
PHYSICIAN'S NAME (Type) I. MAZZARELLA LT MC USNR				U.S. NAVAL HOSPITAL, ANNAPOLIS, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF January 4, 1960		22c. NAME OF CEMETERY OR CREMATORY Annapolis National Cem.		22d. LOCATION (City, town, or county) (State) Annapolis, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE HOPING FUNERAL HOME				ADDRESS 172 West St., Annapolis, Md.		24a. REC'D BY REGISTRAR DATE JAN 5 '60	
				24b. REGISTRAR'S SIGNATURE C. E. S. F. H. H.			

TO HOSPITAL - ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



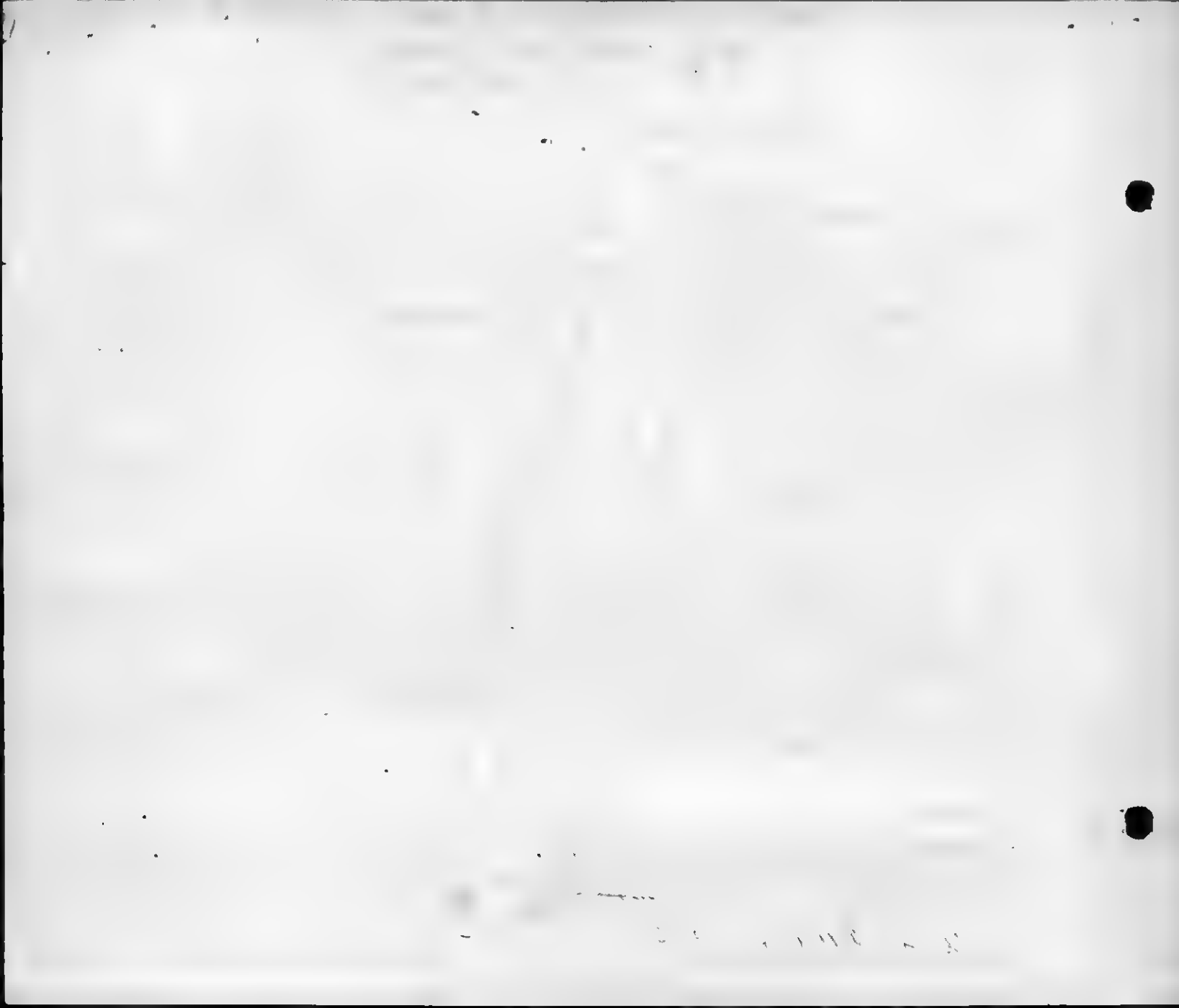
0147 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Croftsville</u>		c. LENGTH OF STAY IN 1b <u>3mo. 13yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Croftsville State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Malaise Brown</u>		4. DATE OF DEATH Month Day Year <u>1 10 1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/10/37</u>
9. AGE (In years last birthday) <u>22</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Harvey</u>		14. MOTHER'S MAIDEN NAME <u>Priscilla</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>434.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Schizophrenic Reaction, Paranoid Type</u>			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) -----	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. -----19--	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	20f. (City or town) (County) (State) -----
21. I certify that I attended the deceased from <u>10/9</u> , 19 <u>46</u> , to <u>1/10</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1/10</u> , 19 <u>60</u> , and that death occurred on <u>8:20 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Malaise Brown</u> M.D. <u>Croftsville State Hospital, Md.</u> <u>1/11/60</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>Malaise Brown, M.D.</u> <u>Croftsville State Hospital, Md.</u> <u>1/11/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>1-15-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Not cremated</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>George H. Nelson</u>		24a. REC'D BY REGISTRAR DATE <u>1-15-60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hearn</u>

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G255 1/27/60 iwk

CERTIFICATE OF DEATH

00115

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A. A. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. A. County</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Benjamin</u> First <u>Brown</u> Middle <u>Sa</u> Last		4. DATE OF DEATH Month <u>1</u> Day <u>19</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Chl</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-25-1894</u>
100. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
13. FATHER'S NAME <u>Benjamin Brown</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Duvall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no) or unknown		16. SOCIAL SECURITY NO. <u>59944-0768</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PERIPHERAL ARTERIOSCLEROSIS</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-15</u> , 19 <u>60</u> , to <u>1-19</u> , 19 <u>60</u> that I last saw the deceased alive on <u>1-15</u> , 19 <u>60</u> , and that death occurred at <u>9:00</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William L. Beck</u> M.D.		ADDRESS (Street, city or town, state) <u>4 Southgate Lane, Annapolis, Md.</u>	
DATE SIGNED <u>1/19/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial 1-24-1960</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Hope Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>A. A. County Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Keese</u> ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 20 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	



CERTIFICATE OF DEATH

Reg. Dist. No.

00116

1. PLACE OF DEATH a. COUNTY <i>Q Q</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Q Q</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>145 Prince George St.</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i>	
f. STREET ADDRESS <i>145 Prince George St</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Catherine E Brown</i>		4. DATE OF DEATH Month <i>1</i> - Day <i>30</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec 21-1874</i>
9. AGE (In years last birthday) <i>85</i> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>	
13. FATHER'S NAME <i>Henry Neiman</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Travis L. Brown</i>		Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i>			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
(b) DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>1-30</i> , 19 <i>60</i> , to <i>1-30</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>19</i> , and that death occurred at <i>2 P</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Frank M Shipley</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>2-1-60</i>	
PHYSICIAN'S NAME (Type) <i>Frank M Shipley</i>		<i>Annapolis</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<i>Burial</i>	<i>2-2-1960</i>	<i>Cedar Bluff</i>	<i>Annapolis Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Galen M. Taylor Sr</i>		ADDRESS <i>Annapolis Md</i>	
24a. REC'D BY REGISTRAR DATE <i>FEB 4 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Unbur & House</i>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be relayed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



0114 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>W</u> Last <u>BURRIS</u>		4. DATE OF DEATH Month <u>January</u> Day <u>9</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 30, 1883</u>
9. AGE (In years lost birthday) <u>76 yrs.</u>		10. IF UNDER 1 YEAR Months <u>76</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>	11. IF UNDER 24 HRS Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TRUCK</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>EDWARD BURRIS</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>INFORMANT</u>	
17. ADDRESS <u>MRS RALPH BRADY</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute myocardial failure</u> <u>592X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>chronic arteriosclerotic heart disease</u> DUE TO (c) <u>chronic nephritis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 8, 1960</u> to <u>Jan 9, 1960</u> that I last saw the deceased alive on <u>Jan 8, 1960</u> , and that death occurred at <u>1:55 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Emily H. Wilson</u> M.D.		ADDRESS (Street, city or town, state) <u>Lothian Md</u> DATE SIGNED <u>1-11-60</u>	
PHYSICIAN'S NAME (Type) <u>Emily H. Wilson</u>		<u>Lothian, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-12-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Cocke Grove Del.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 14 '60</u>	
ADDRESS <u>Annapolis Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please refile carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>A. A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b <u>LIFE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>110 CHESAPEAKE AVE</u>		d. STREET ADDRESS <u>110 CHESAPEAKE AVE</u>	
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>T.</u> Middle <u>CHURCHILL</u> Last		4. DATE OF DEATH Month <u>1</u> Day <u>22</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 1st 1879</u>
9. AGE (In years last birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAINTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN CONTRACTOR</u>	
11. BIRTHPLACE (State or foreign country) <u>Annapolis Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Churchill</u>		14. MOTHER'S MAIDEN NAME <u>Sarah E James</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>Grace V. Churchill</u>	
17. INFORMANT <u>(2)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized metastases</u> <u>177X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cancer of prostate</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct 12</u> , 19 <u>54</u> , to <u>Jan 22</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Dec 15</u> , 19 <u>54</u> , and that death occurred at <u>1:05 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Maurice F. Klawans</u> M.D.		ADDRESS (Street, city or town, state) <u>31 South St</u> DATE SIGNED <u>1/24/60</u>	
PHYSICIAN'S NAME (Type) <u>MAURICE F. KLAWANS</u>		<u>Annapolis Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>1-25-1960</u>	<u>CEDAR BLUFF</u>	<u>ANNAPOLIS MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons</u>		ADDRESS <u>Annapolis Md</u>	
24a. REC'D BY REGISTRAR <u>JAN 25 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

00119

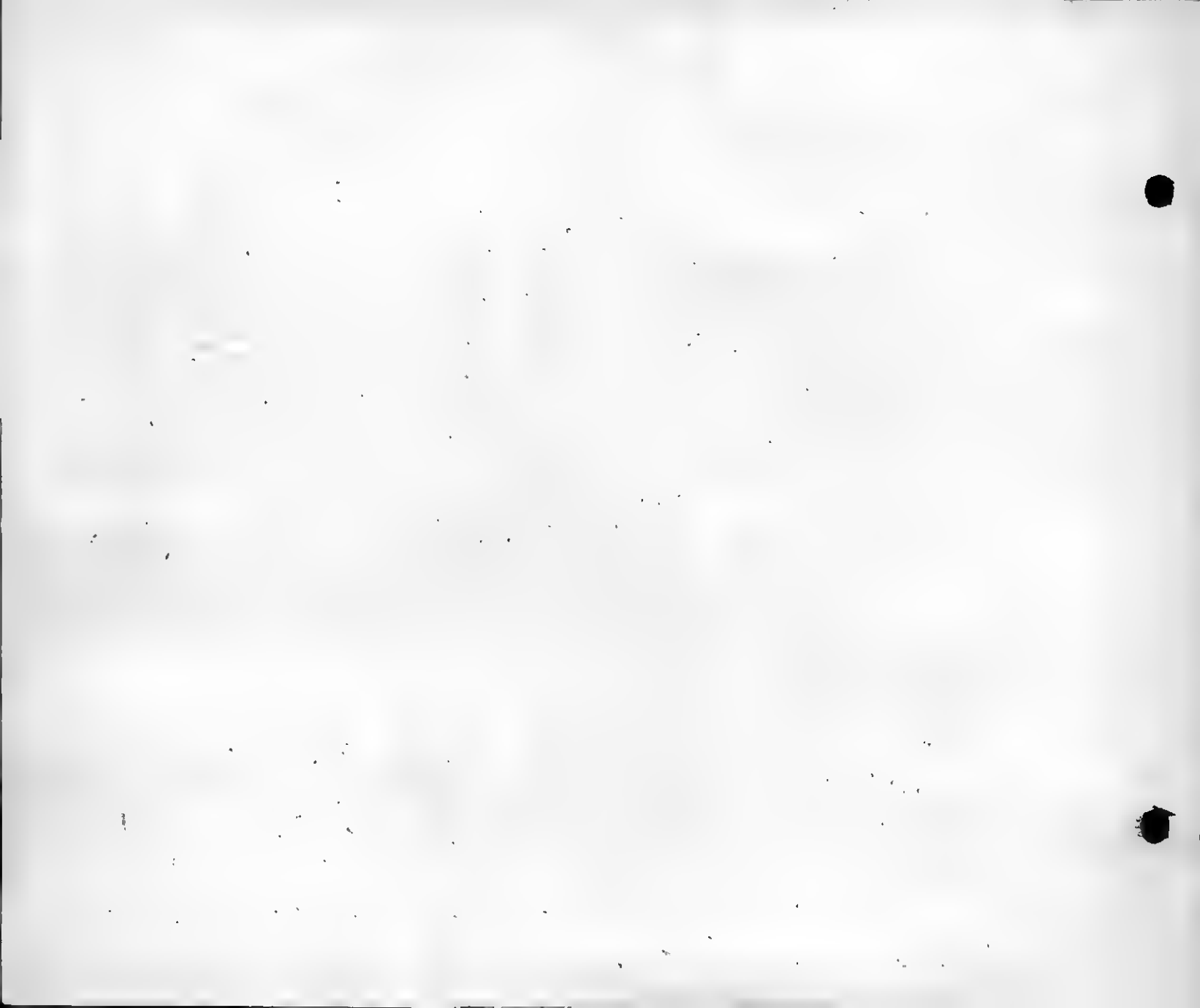
0116

1. PLACE OF DEATH a. COUNTY <u>A. D. County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) o. STATE <u>Maryland</u> COUNTY <u>A. D. County</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>100 Lewis Drive</u>		d. STREET ADDRESS <u>100 Lewis Drive</u>	
3. NAME OF DECEASED (Type or print) <u>George E. Coates</u> First Middle Last		4. DATE OF DEATH Month <u>1</u> Day <u>25</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-10-1900</u> 59 yrs.
9. AGE (In years last birthday) <u>59</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William Coates</u>	
14. MOTHER'S MAIDEN NAME <u>Mamie Adams</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>111-111111</u>		17. INFORMANT Address <u>Sarah Coates 100 Lewis Drive</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of the Bladder</u> 181.8 DUE TO (b) <u>And left Water</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>2 months</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov 6, 1959</u> to <u>Jan 25, 1960</u> that I last saw the deceased alive on <u>Jan 25, 1960</u> and that death occurred at <u>9:00 AM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>1/26/60</u>	
PHYSICIAN'S NAME (Type) <u>Annapolis</u>		M.D. <u>110-4a Street</u>	
22a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>1-28-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Keese</u> ADDRESS <u>Anna Md</u>		24a. REC'D BY REGISTRAR <u>JAN 27 '60</u>	24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



0117
CERTIFICATE OF DEATH

Reg. Dist. No.

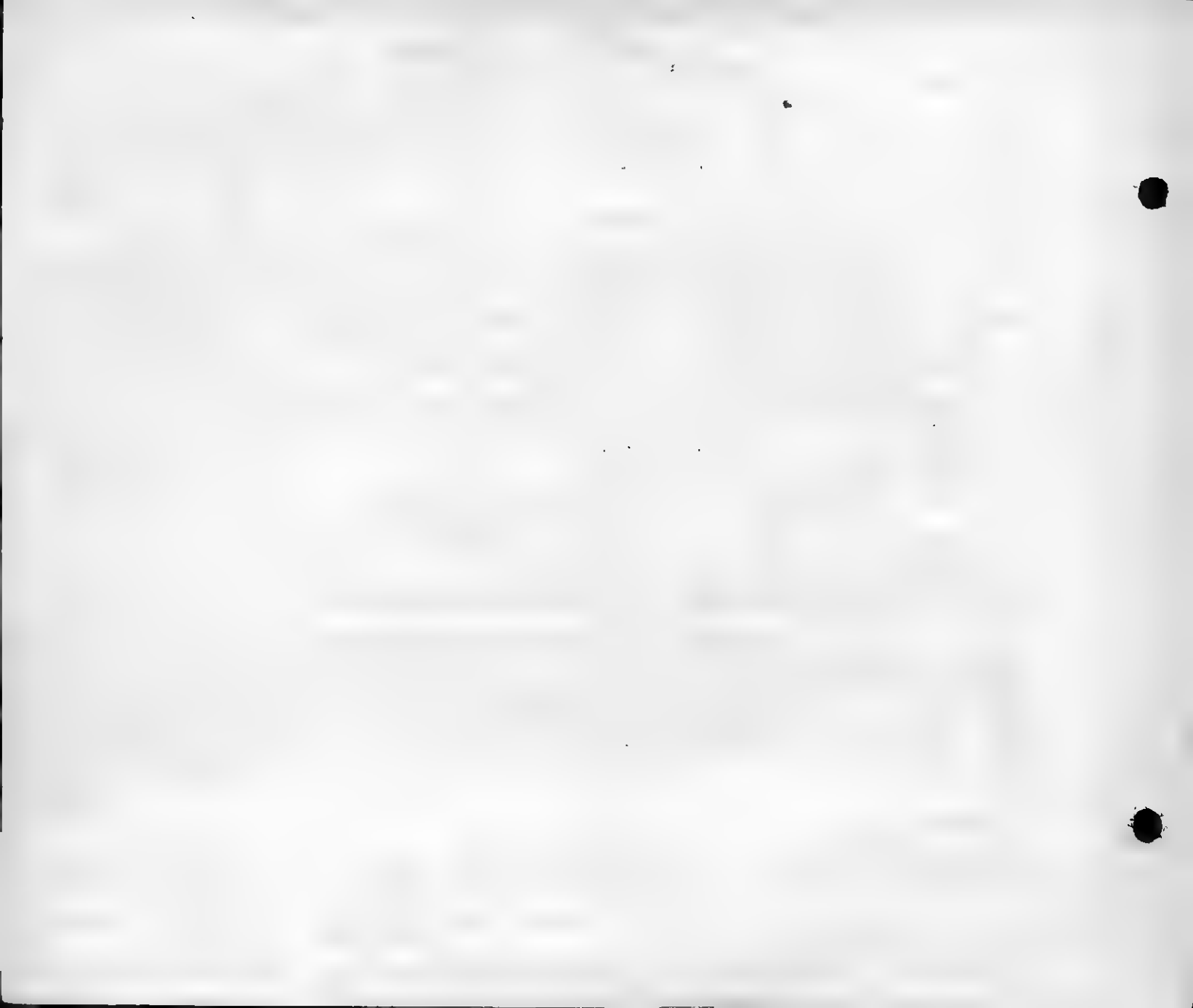
00120

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>A.A. CO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS, MD</u>		c. LENGTH OF STAY IN 1b <u>30 yrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNE ARUNDEL GEN. HOSP.</u>		d. STREET ADDRESS <u>1312 WEST ST.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOSEPH G COHEN</u>		4. DATE OF DEATH Month Day Year <u>JAN. 15, 1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 22, 1890</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ASST. MGR.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CONVALESCENT HOME, WASHINGTON, DC</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>NATHAN COHEN</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO.</u>		16. SOCIAL SECURITY NO. <u>214-16-8842</u>	
17. INFORMANT <u>ROBERT COHEN</u> Address <u>220 S. CHERRY GROVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Re. Pneumonitis, et. trach.</u> 492X DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chs. Emphysema - Aplastic Anemia or Aleukemic Leukemia</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/11/60</u> to <u>1/15/60</u> , that I last saw the deceased alive on <u>1/15/60</u> , and that death occurred at <u>11:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Maurice F. Klawans</u> M.D.		ADDRESS (Street, city or town, state) <u>31 South 44th St. Baltimore, Md.</u>	
DATE SIGNED <u>1/15/60</u>			
PHYSICIAN'S NAME (Type) <u>MAURICE F. KLAWANS</u>		<u>Annapolis, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>JAN. 17, 60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MISHKON ISRAEL</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hoppe & Son</u> ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 20 60</u> DATE	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



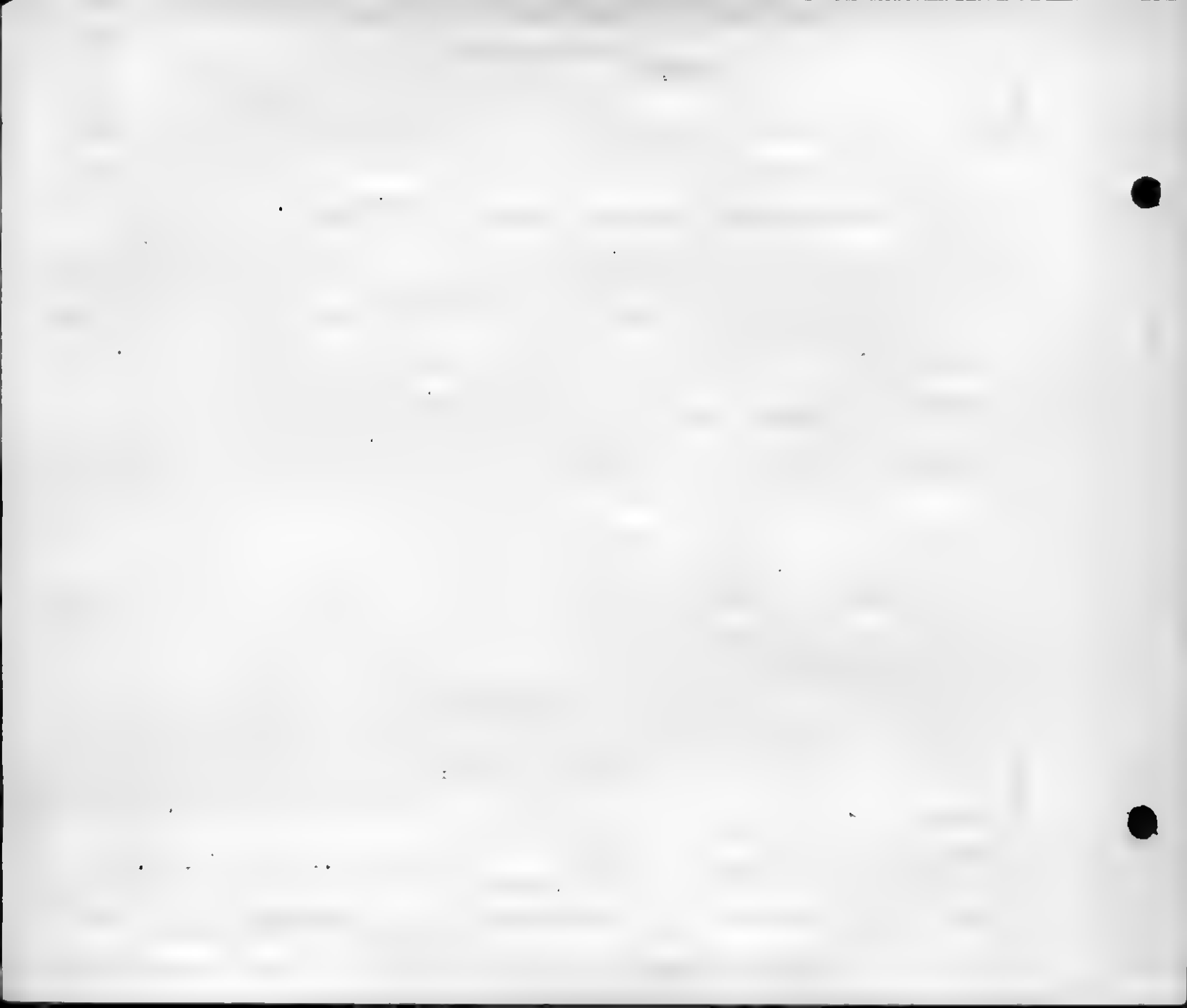
CERTIFICATE OF DEATH

Reg. Dist. No.

00121

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 14 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		d. STREET ADDRESS 152 Jefferson St.	
3. NAME OF DECEASED (Type or print) First Helen Middle Elizabeth Last COMO		4. DATE OF DEATH Month January Day 27 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 6, 1958
9. AGE (In years last birthday) 1 yrs.		10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Carl Edward COMO		14. MOTHER'S MAIDEN NAME Patricia Ann TUCKER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Vomiting and Diarrhea with dehydration 481X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Influenza like illness DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 day 4 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1/23 , 19 60 , to 1/27/60 , 19 60 , that I last saw the deceased alive on 1/27/60 , 19 60 , and that death occurred on 1:25P , from the causes and on the date stated above.			
ACTUAL SIGNATURE Philip Briscoe		ADDRESS (Street, city or town, state) 95 Cathedral St., Annapolis, Md.	
DATE SIGNED 1/27/60			
PHYSICIAN'S NAME (Type) Philip Briscoe		ADDRESS 95 Cathedral St., Annapolis, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-30-1960	22c. NAME OF CEMETERY OR CREMATORY Cedar Bluffs	22d. LOCATION (City, town, or county) (State) Annapolis Md
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons		24a. REC'D BY REGISTRAR DATE FEB 2 '60	24b. REGISTRAR'S SIGNATURE C. L. G. F. F.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



0149 CERTIFICATE OF DEATH

Reg. Dist. No.

00122

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville c. LENGTH OF STAY IN 1b 11mo. 22 days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 401 Oxford Court e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Emma Conway		4. DATE OF DEATH Month Day Year 1 25 1960	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH December 28, 1886
9. AGE (In years lost birthday) 73 yrs		10. IF UNDER 1 YEAR Months Days 73	11. IF UNDER 24 HRS Hours Min. 73
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Butler		14. MOTHER'S MAIDEN NAME Alice Larkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anemia 204.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Lymphatic Leukemia DUE TO (c) 1 year PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. - - - 19 p. m. - - - 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 2/3 , 19 59 , to 1/25 , 19 60 , that I last saw the deceased alive on 1/25 , 19 60 , and that death occurred at 5:45 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Crownsville State Hospital, Md. 1/25/60			
ACTUAL SIGNATURE Lionel McHenry Mapp, M. D.		PHYSICIAN'S NAME (Type) Crownsville State Hospital, Md. 1/25/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-2-60	22c. NAME OF CEMETERY OR CREMATORY Crownsville State Hosp.	22d. LOCATION (City, town, or county) (State) Crownsville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Robert S. K...		24a. REC'D BY REGISTRAR DATE FEB 2 '60	24b. REGISTRAR'S SIGNATURE Robert S. K...



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00123

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> 0119 MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS - MD.</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. Anne Arundel General.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>1</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore MD</u> d. STREET ADDRESS <u>1402 3rd Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Alvin</u> Last <u>Crosby</u>		4. DATE OF DEATH Month <u>1</u> Day <u>13</u> Year <u>1960</u>		5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-15-03</u>		9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Aggr. Sealtest.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>DAIRY</u>				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>John A. Crosby</u>								14. MOTHER'S MAIDEN NAME <u>Henrietta Harrison</u>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u> </u>				16. SOCIAL SECURITY NO. <u>215-10-3904</u>				17. INFORMANT <u>Edgar Crosby</u> Address <u>Friendships Md.</u>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Coronary Disease</u> (c) <u>Sudden</u> </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH <u> </u> </div> </div> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <u> </u>																			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>											
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>				20f. (City or town) (County) (State) <u> </u>							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																			
ACTUAL SIGNATURE <u>E. Linhardt</u>								M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
EXAMINER'S NAME (Type) <u>E. Linhardt</u>								DATE SIGNED <u>1/13/60</u>											
22a. BURIAL-CREMATATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>1-16-60</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Friendships</u>				22d. LOCATION (City, town, or county) (State) <u>Anne Arundel Md.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hutchins Funeral Home, Owings Md.</u>								24a. REC'D BY REGISTRAR DATE <u>JAN 18 '60</u>								24b. REGISTRAR'S SIGNATURE <u> </u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the date, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



0120

CERTIFICATE OF DEATH

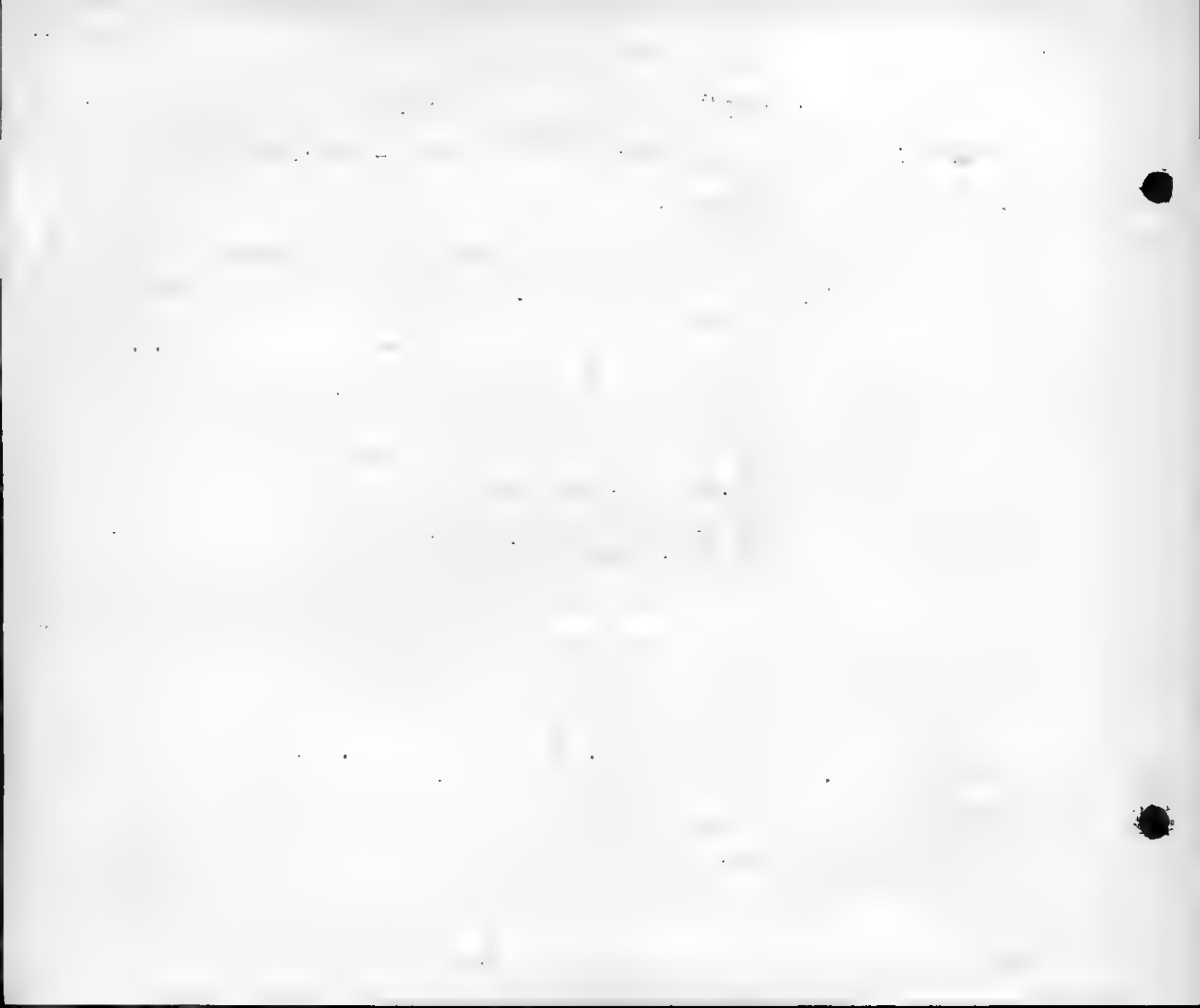
Reg. Dist. No.

00124

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN lb 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospita l		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle CATHERINE Last DAWSON		4. DATE OF DEATH Month January Day 19 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1, 1888
9. AGE (in years lost birthday) yrs. 71		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Mulroy		14. MOTHER'S MAIDEN NAME MARY AGNES McEvoy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe secondary anemia 578x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Massive hemorrhage from lower bowel Cause undetermined (c)		INTERVAL BETWEEN ONSET AND DEATH ??? ???	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 19, 1960 to Jan. 19, 1960 that I last saw the deceased alive on Jan. 19, 1960 and that death occurred 11:45P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Maurice Klawans M.D.		ADDRESS (Street, city or town, state) 31 Southgate Ave DATE SIGNED 1/20/60	
PHYSICIAN'S NAME (Type) Maurice Klawans		Annapolis Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/22/60	22c. NAME OF CEMETERY OR CREMATORY Woodfield	22d. LOCATION (City, town, or county) (State) Galesville Md
23. FUNERAL DIRECTOR'S SIGNATURE Bernard C. Hardisty		24a. REC'D BY REGISTRAR DATE JAN 25 '60	
ADDRESS Galesville, Md		24b. REGISTRAR'S SIGNATURE William L. Farris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



0150
CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) b. STATE <u>Maryland</u> c. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Camp Meade Road</u>		d. STREET ADDRESS <u>Camp Meade Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ISAIAH - DURNER</u>		4. DATE OF DEATH Month Day Year <u>JANUARY 15, 19 60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>23 July 1873</u>
9. AGE (In years last birthday) <u>86</u> yrs		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watchman (ret.)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>John Geiss</u>	
11. BIRTHPLACE (State or foreign country) <u>Severn, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>(Unknown) Durner</u>		14. MOTHER'S MAIDEN NAME <u>(Unknown)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT Address <u>Mrs. Lyndall Warfield, Same As #2</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Infarct</u> TO (b) <u>Generalized Atherosclerosis</u> DUE TO (c) <u>Cardio Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>2 years</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture Right hip</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12:00</u> 19 <u>59</u> to <u>Jan 15 - 60</u> that I last saw the deceased alive on <u>Jan 13</u> 19 <u>60</u> and that death occurred at <u>5:15 AM</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph Lipskey</u> M.D.		ADDRESS (Street, city, town, state) <u>Bellevue Md</u> DATE SIGNED <u>1/15/60</u>	
PHYSICIAN'S NAME (Type) <u>JOSEPH LIPSKEY</u>			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>13 January 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Friendship</u>		22d. LOCATION (City, town, or county) (State) <u>A.A. Co. Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. V. Singleton</u>		24. REC'D BY REGISTRAR ADDRESS <u>John Burnie, Md</u>	
25. REGISTRAR'S SIGNATURE <u>Arthur L. Kinn</u>		26. REGISTRAR'S SIGNATURE	

TO HOSPITAL 60. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



0151

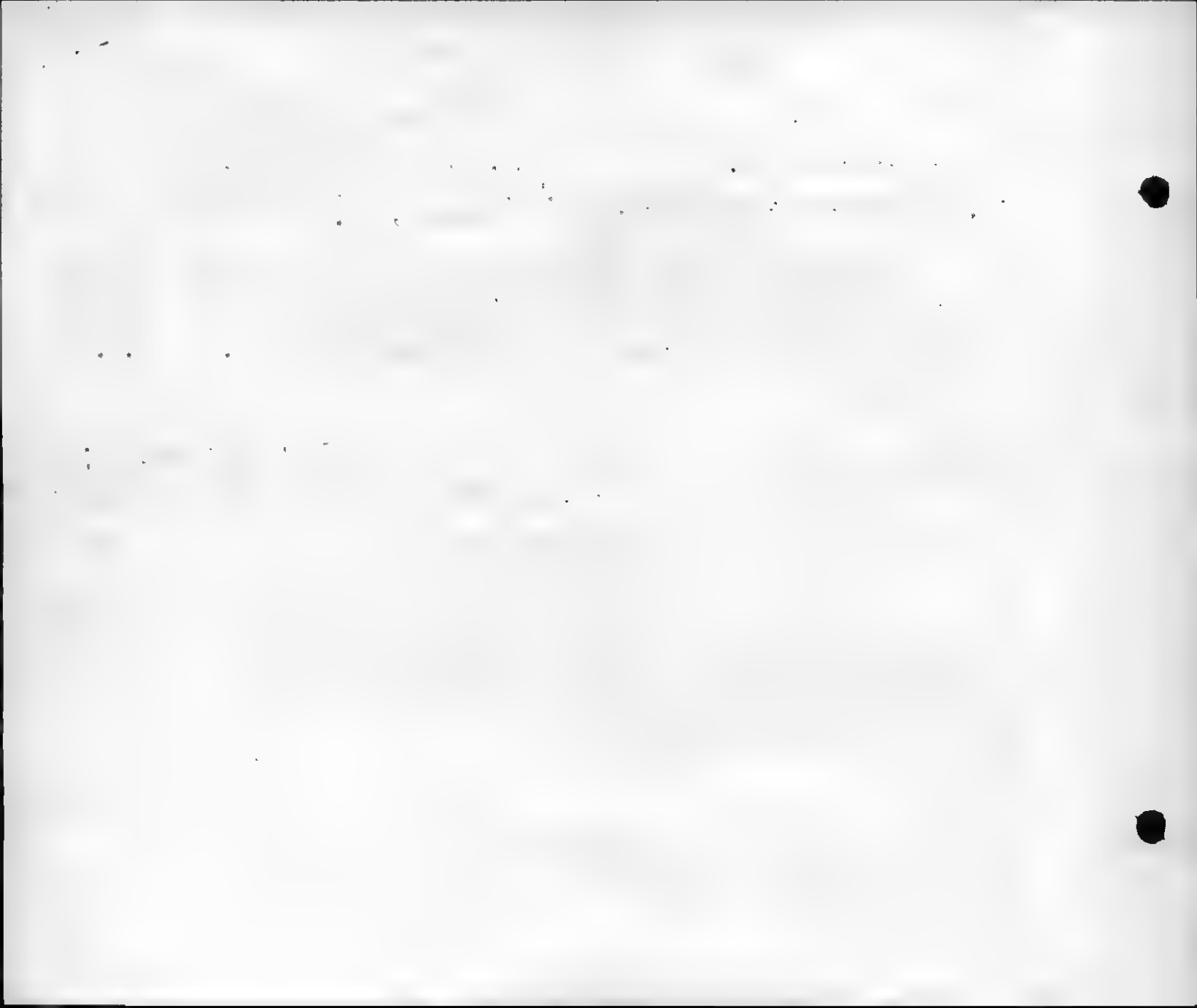
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural—Pasadena, Md. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt. 3, Box 122, Green Haven, Pasadena, Md.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. 3, Pasadena, Md. d. STREET ADDRESS Rt. 3, Box 122, Green Haven, Pasadena, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Pauline Theresa Ernst		4. DATE OF DEATH Month January Day 18 Year 1960			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 11/27/1918	9. AGE (In years last birthday) 41 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory		10b. KIND OF BUSINESS OR INDUSTRY Factory		11. BIRTHPLACE (State or foreign country) Baltimore, city, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Ernst		14. MOTHER'S MAIDEN NAME Berger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no If yes, give war or dates of service		16. SOCIAL SECURITY NO. 217-09-8365		INFORMANT Mary Helmstetter -Ft. Smallwood Rd. Pasadena, Md. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the breast 170X DUE TO (b) Metastatic carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from July 10, 1957 , to Jan. 18, 1960 , that I last saw the deceased alive on Jan. 17, 1960 and that death occurred at 3 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE R.M. McLaughlin		M.D. R.F. 08 Box 442 Pasadena, Md.		DATE SIGNED Jan. 18, 1960	
PHYSICIAN'S NAME (Type) R.M. McLaughlin					
22a. BURIAL, CREMATION, REMOVAL (Specify) buried		22b. DATE THEREOF 21 Jan. 1960		22c. NAME OF CEMETERY OR CREMATORY Green Haven Bur.	
22d. LOCATION (City, town, or county) Green Haven, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE R. V. Longteton		ADDRESS Green Haven, Md.		24a. REC'D BY REGISTRAR Jan 20 '60	
24b. REGISTRAR'S SIGNATURE Robert L. Kline					

TO HOSPITAL. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



0121 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. LENGTH OF STAY IN 1b 4 hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle Lee Last ESTEP		4. DATE OF DEATH Month January Day 10 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 10, 1960
9. AGE (In years lost birthday) yrs 4		10. IF UNDER 1 YEAR Months 4 Days 30	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Newborn		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) U.S.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Oden McClain ESTEP		14. MOTHER'S MAIDEN NAME Margaret Agnes SMITH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Hospital Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Prematurity (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 10, 1960 to Jan. 10, 1960 that I last saw the deceased alive on Jan. 10, 1960 and that death occurred at 5:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Medical Building DATE SIGNED ACTUAL SIGNATURE Clayton Norton M.D. PHYSICIAN'S NAME (Type) Clayton Norton Severna Park, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/11/60	
22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE Bernard Hardisty		24a. REC'D BY REGISTRAR DATE JAN 14 '60	
24b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

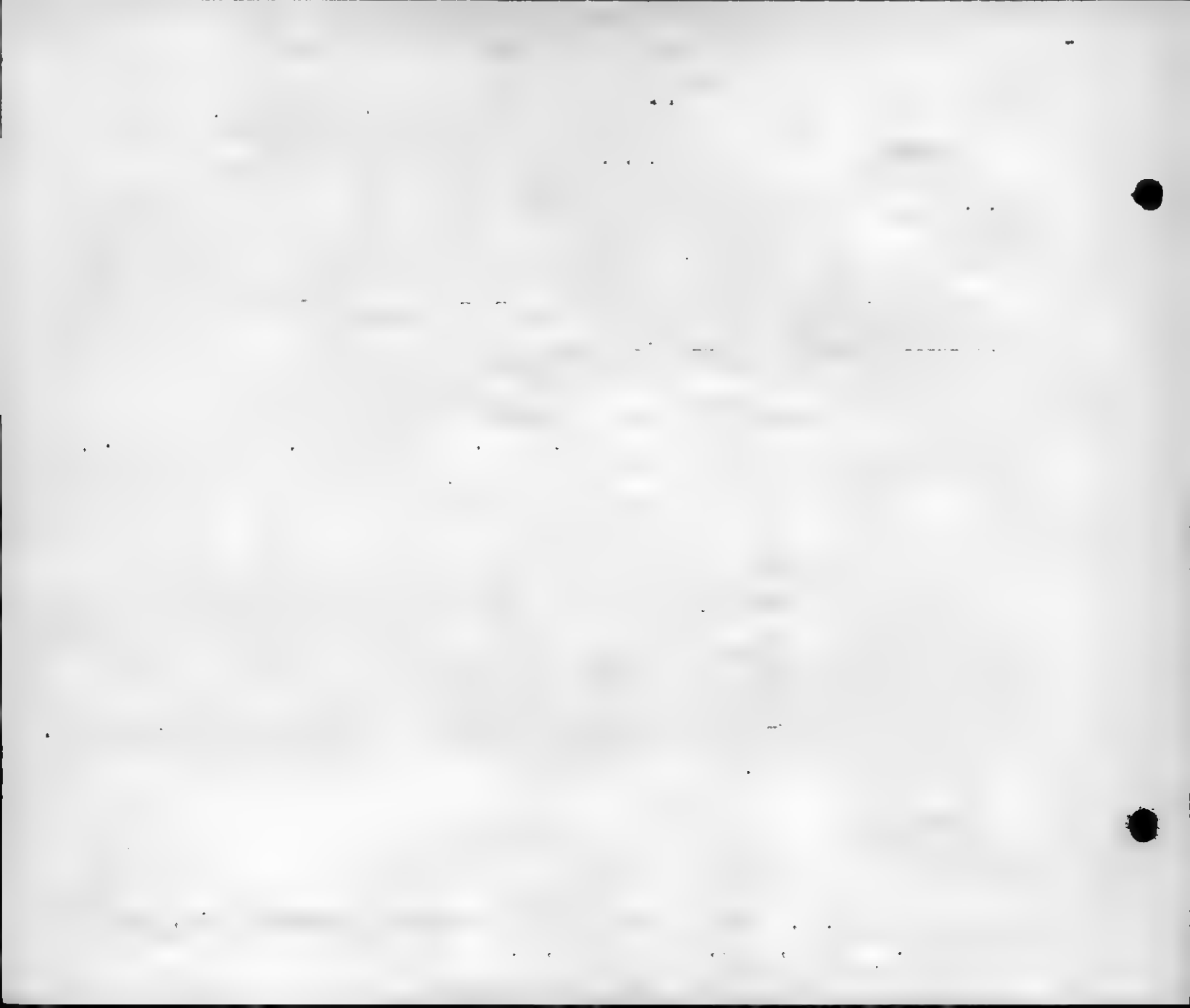
00128

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SHADYSIDE		c. LENGTH OF STAY IN lb D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. NAVAL HOSPITAL, ANNAPOLIS, MARYLAND		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First PEGGY Middle JACQUELINE Last EVANS		4. DATE OF DEATH Month 1 Day 29 Year 1960	
5. SEX Female	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-10-29
9. AGE (In years for birthday) 30-31 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE SECRETARY		10b. KIND OF BUSINESS OR INDUSTRY Own Home PAGE ELECTRONIC ENGINEERS	
11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CECIL WHALEY		14. MOTHER'S MAIDEN NAME MABEL THRAILKILL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT HUSBAND. FRED EVANS, AVE., IDLEWILDE, MARYLAND		Address FREDERICK & WINTERS	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MULTIPLE HEAD INJURIES DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH SUDDEN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (AUTO ACCIDENT)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) (AUTO ACCIDENT)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 0925 1-29-60 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Car accident		20f. (City or town) (County) (State) Shadyside, Anne Arundel, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>[Signature]</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) ELW		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 1-30-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF FEB. 2, 1960	
22c. NAME OF CEMETERY OR CREMATORY ARLINGTON NATIONAL CEMETERY		22d. LOCATION (City, town, or county) (State) ARLINGTON COUNTY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE WARNER E. PUMPHREY, INC. SILVER SPRING, MD. <i>Raymond A. Gaska</i>		24a. REC'D BY REGISTRAR DATE FEB 3 '60	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Finner</i>			

MEDICAL CERTIFICATION

TO DEPUTY CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



0152

CERTIFICATE OF DEATH

00129

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 6yrs. 13 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 923 Sharp Street			
3. NAME OF DECEASED (Type or print) First Austin Middle Farmer Last Farmer				4. DATE OF DEATH Month 1 Day 30 Year 19 60			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1889		9. AGE (In years lost birthday) 70 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown			10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Carter Palmer				14. MOTHER'S MAIDEN NAME Meholey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 705-10-7124		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 304X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Brain Syndrome with Senile Brain Disease DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) -----			
20c. TIME OF INJURY Month, Day, Year Hour o m. 19 p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1/17 , 19 54 , to 1/30 , 19 60 , that I last saw the deceased alive on 1/30 , 19 60 , and that death occurred at 6:55 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 2/1/60							
ACTUAL SIGNATURE Hildegard Heard Reissman				M.D. Crownsville State Hospital, Md. 2/1/60			
PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M. D.				Crownsville State Hospital, Md. 2/1/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 2-26-60		22c. NAME OF CEMETERY OR CREMATORY Mid University		22d. LOCATION (City, town or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE John Reese				ADDRESS Annapolis Md		24a. REC'D BY REGISTRAR DATE FEB 3 '60	
				24b. REGISTRAR'S SIGNATURE William L. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

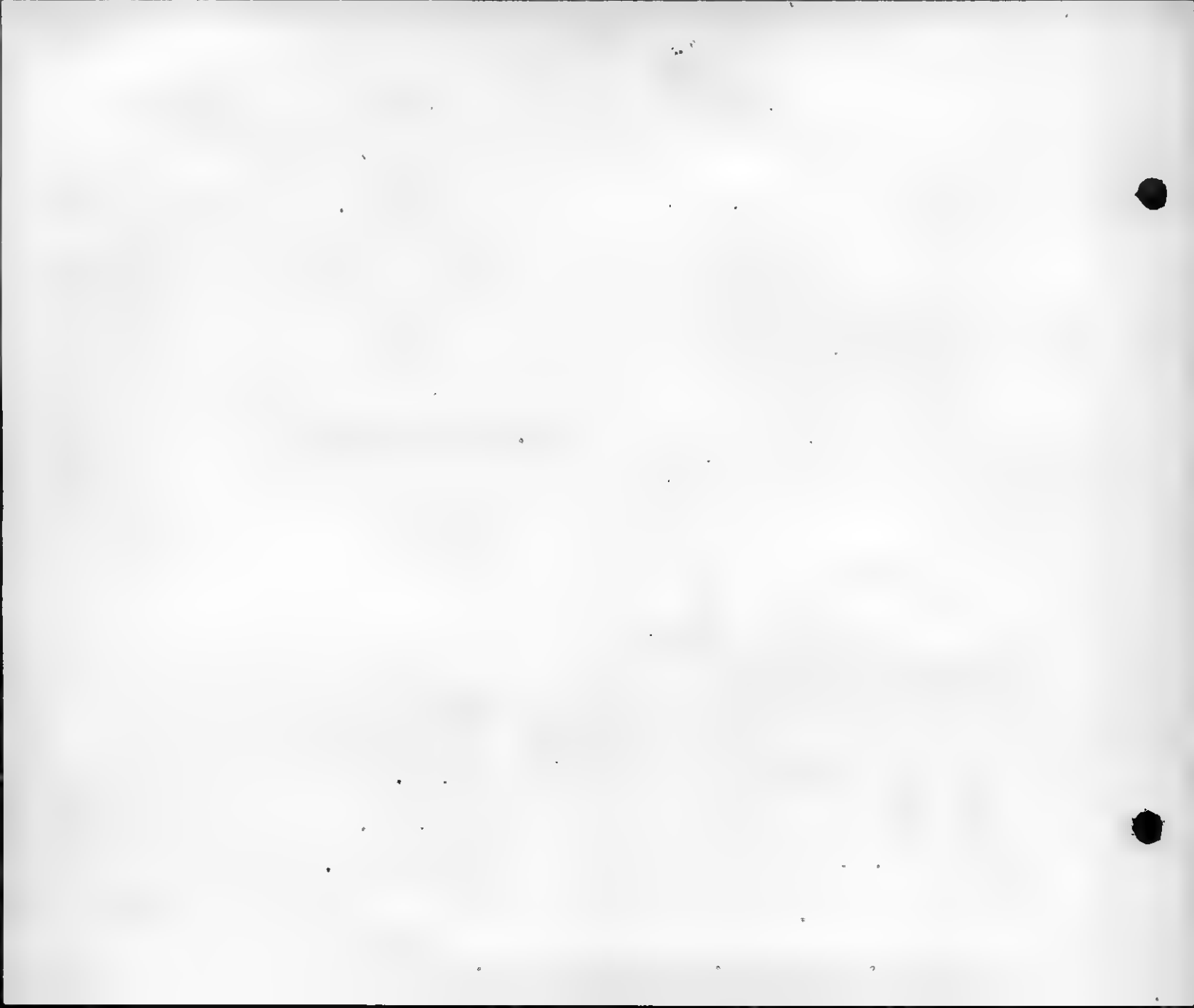
Items 12, 13 Film G255 2-5-60 et

CERTIFICATE OF DEATH

Reg. Dist. No.

00130

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital		d. STREET ADDRESS 81 West St.	
3. NAME OF DECEASED (Type or print) First SANTO Middle FAZIO Last FAZIO		4. DATE OF DEATH Month January Day 28 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1890
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR: Months 6 Days 9 Hours 0 Min 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber		10b. KIND OF BUSINESS OR INDUSTRY Barber	
11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? Italy	
13. FATHER'S NAME Pasquale Fazio		14. MOTHER'S MAIDEN NAME —	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No	
INFORMANT Mrs. Josephine Squilace		Address 2001 Eagle St	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia DUE TO Carbosis of liver Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Due to (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 8 days Carbosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Late Latent Syphilis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from January 20, 1960 to January 28, 1960 , that I last saw the deceased alive on January 28, 1960 , and that death occurred at 2:25 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE R. L. Richardson		ADDRESS (Street, city or town, state) 110 Clay St., Annapolis, Md.	
DATE SIGNED 1/28/60			
PHYSICIAN'S NAME (Type) R. L. Richardson		Annapolis, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Feb. 1, 1960	22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem	22d. LOCATION (City, town, or county) (State) 4300 Old Frederick Baltimore Md.
23. FUNERAL DIRECTOR'S SIGNATURE Thomas J. Kenny, Inc.		ADDRESS 1600 Hollins St.	
24a. REC'D BY REGISTRAR FEB 1 '60		24b. REGISTRAR'S SIGNATURE Clifford S. Hanna	



CERTIFICATE OF DEATH

Reg. Dist. No.

00131

0153

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 9mo. 1 year 28 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Crownsville State Hospital				e. STREET ADDRESS 2637 Lauretta Avenue			
3. NAME OF DECEASED (Type or print) First Rose Middle Anna Last Fleming				4. DATE OF DEATH Month 1 Day 22 Year 1960			
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH January 13, 1902	
9. AGE (In years last birthday) 58		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Pamplie Gary				14. MOTHER'S MAIDEN NAME Mattie Booker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) Unknown		16. SOCIAL SECURITY NO 220-22-1645		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 443x DUE TO Arteriosclerotic cardiovascular disease with hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) old cerebral hemorrhage							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 3/24 , 19 58 to 1/22 , 19 60 , that I last saw the deceased alive on 1/22 , 19 60 , and that death occurred at 2:35 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Hildegard Heard Reissman M.D.				ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 1/22/60			
PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M. D.				ADDRESS Crownsville State Hospital, Md. DATE SIGNED 1/22/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-26-60		22c. NAME OF CEMETERY OR CREMATORY Ashburton Mem. Pk.		22d. LOCATION (City, town, or county) (State) Balt., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles B. Lewis ADDRESS 11634 N. Broadway				24a. REC'D BY REGISTRAR DATE JAN 25 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

15. 1990. 1991. 1992. 1993. 1994. 1995. 1996. 1997. 1998. 1999. 2000. 2001. 2002. 2003. 2004. 2005. 2006. 2007. 2008. 2009. 2010. 2011. 2012. 2013. 2014. 2015. 2016. 2017. 2018. 2019. 2020. 2021. 2022. 2023. 2024. 2025. 2026. 2027. 2028. 2029. 2030. 2031. 2032. 2033. 2034. 2035. 2036. 2037. 2038. 2039. 2040. 2041. 2042. 2043. 2044. 2045. 2046. 2047. 2048. 2049. 2050. 2051. 2052. 2053. 2054. 2055. 2056. 2057. 2058. 2059. 2060. 2061. 2062. 2063. 2064. 2065. 2066. 2067. 2068. 2069. 2070. 2071. 2072. 2073. 2074. 2075. 2076. 2077. 2078. 2079. 2080. 2081. 2082. 2083. 2084. 2085. 2086. 2087. 2088. 2089. 2090. 2091. 2092. 2093. 2094. 2095. 2096. 2097. 2098. 2099. 2100. 2101. 2102. 2103. 2104. 2105. 2106. 2107. 2108. 2109. 2110. 2111. 2112. 2113. 2114. 2115. 2116. 2117. 2118. 2119. 2120. 2121. 2122. 2123. 2124. 2125. 2126. 2127. 2128. 2129. 2130. 2131. 2132. 2133. 2134. 2135. 2136. 2137. 2138. 2139. 2140. 2141. 2142. 2143. 2144. 2145. 2146. 2147. 2148. 2149. 2150. 2151. 2152. 2153. 2154. 2155. 2156. 2157. 2158. 2159. 2160. 2161. 2162. 2163. 2164. 2165. 2166. 2167. 2168. 2169. 2170. 2171. 2172. 2173. 2174. 2175. 2176. 2177. 2178. 2179. 2180. 2181. 2182. 2183. 2184. 2185. 2186. 2187. 2188. 2189. 2190. 2191. 2192. 2193. 2194. 2195. 2196. 2197. 2198. 2199. 2200. 2201. 2202. 2203. 2204. 2205. 2206. 2207. 2208. 2209. 2210. 2211. 2212. 2213. 2214. 2215. 2216. 2217. 2218. 2219. 2220. 2221. 2222. 2223. 2224. 2225. 2226. 2227. 2228. 2229. 2230. 2231. 2232. 2233. 2234. 2235. 2236. 2237. 2238. 2239. 2240. 2241. 2242. 2243. 2244. 2245. 2246. 2247. 2248. 2249. 2250. 2251. 2252. 2253. 2254. 2255. 2256. 2257. 2258. 2259. 2260. 2261. 2262. 2263. 2264. 2265. 2266. 2267. 2268. 2269. 2270. 2271. 2272. 2273. 2274. 2275. 2276. 2277. 2278. 2279. 2280. 2281. 2282. 2283. 2284. 2285. 2286. 2287. 2288. 2289. 2290. 2291. 2292. 2293. 2294. 2295. 2296. 2297. 2298. 2299. 2300. 2301. 2302. 2303. 2304. 2305. 2306. 2307. 2308. 2309. 2310. 2311. 2312. 2313. 2314. 2315. 2316. 2317. 2318. 2319. 2320. 2321. 2322. 2323. 2324. 2325. 2326. 2327. 2328. 2329. 2330. 2331. 2332. 2333. 2334. 2335. 2336. 2337. 2338. 2339. 2340. 2341. 2342. 2343. 2344. 2345. 2346. 2347. 2348. 2349. 2350. 2351. 2352. 2353. 2354. 2355. 2356. 2357. 2358. 2359. 2360. 2361. 2362. 2363. 2364. 2365. 2366. 2367. 2368. 2369. 2370. 2371. 2372. 2373. 2374. 2375. 2376. 2377. 2378. 2379. 2380. 2381. 2382. 2383. 2384. 2385. 2386. 2387. 2388. 2389. 2390. 2391. 2392. 2393. 2394. 2395. 2396. 2397. 2398. 2399. 2400. 2401. 2402. 2403. 2404. 2405. 2406. 2407. 2408. 2409. 2410. 2411. 2412. 2413. 2414. 2415. 2416. 2417. 2418. 2419. 2420. 2421. 2422. 2423. 2424. 2425. 2426. 2427. 2428. 2429. 2430. 2431. 2432. 2433. 2434. 2435. 2436. 2437. 2438. 2439. 2440. 2441. 2442. 2443. 2444. 2445. 2446. 2447. 2448. 2449. 2450. 2451. 2452. 2453. 2454. 2455. 2456. 2457. 2458. 2459. 2460. 2461. 2462. 2463. 2464. 2465. 2466. 2467. 2468. 2469. 2470. 2471. 2472. 2473. 2474. 2475. 2476. 2477. 2478. 2479. 2480. 2481. 2482. 2483. 2484. 2485. 2486. 2487. 2488. 2489. 2490. 2491. 2492. 2493. 2494. 2495. 2496. 2497. 2498. 2499. 2500. 2501. 2502. 2503. 2504. 2505. 2506. 2507. 2508. 2509. 2510. 2511. 2512. 2513. 2514. 2515. 2516. 2517. 2518. 2519. 2520. 2521. 2522. 2523. 2524. 2525. 2526. 2527. 2528. 2529. 2530. 2531. 2532. 2533. 2534. 2535. 2536. 2537. 2538. 2539. 2540. 2541. 2542. 2543. 2544. 2545. 2546. 2547. 2548. 2549. 2550. 2551. 2552. 2553. 2554. 2555. 2556. 2557. 2558. 2559. 2560. 2561. 2562. 2563. 2564. 2565. 2566. 2567. 2568. 2569. 2570. 2571. 2572. 2573. 2574. 2575. 2576. 2577. 2578. 2579. 2580. 2581. 2582. 2583. 2584. 2585. 2586. 2587. 2588. 2589. 2590. 2591. 2592. 2593. 2594. 2595. 2596. 2597. 2598. 2599. 2600. 2601. 2602. 2603. 2604. 2605. 2606. 2607. 2608. 2609. 2610. 2611. 2612. 2613. 2614. 2615. 2616. 2617. 2618. 2619. 2620. 2621. 2622. 2623. 2624. 2625. 2626. 2627. 2628. 2629. 2630. 2631. 2632. 2633. 2634. 2635. 2636. 2637. 2638. 2639. 2640. 2641. 2642. 2643. 2644. 2645. 2646. 2647. 2648. 2649. 2650. 2651. 2652. 2653. 2654. 2655. 2656. 2657. 2658. 2659. 2660. 2661. 2662. 2663. 2664. 2665. 2666. 2667. 2668. 2669. 2670. 2671

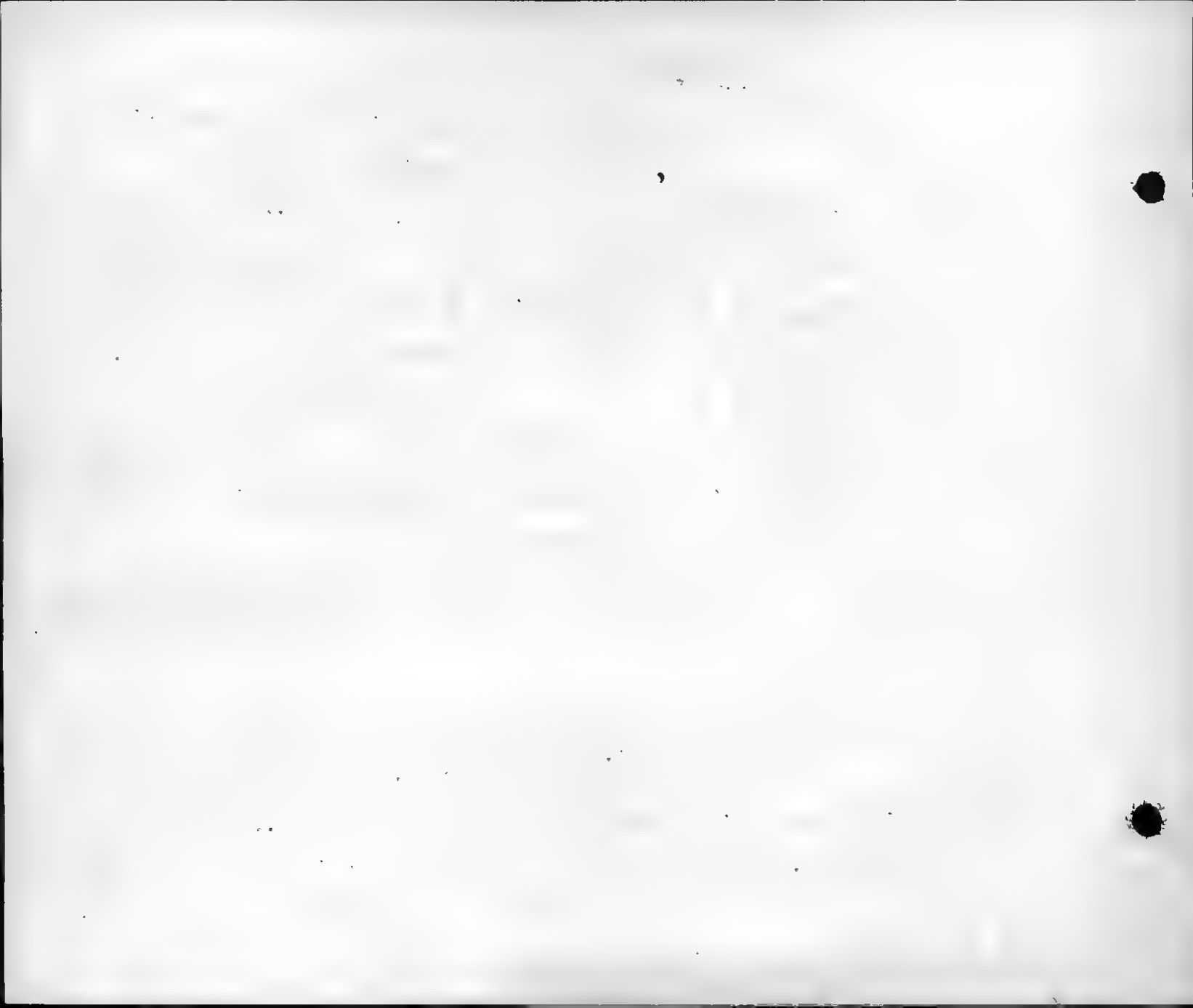
• • • • •

0124 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Annapolis | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
13 Annapolis | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Anne Arundel General Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Robert Middle THOMAS Last FORD | | 4. DATE OF DEATH
Month January Day 11 Year 1960 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
March 27, 1892 |
| 9. AGE (in years last birthday)
67 yrs. | | 10. IF UNDER 1 YEAR
Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Painter | | 10b. KIND OF BUSINESS OR INDUSTRY
Boat Building | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
Charles Henry Ford | | 14. MOTHER'S MAIDEN NAME
Mary Davis | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
Yes | | 16. SOCIAL SECURITY NO.
WW1 | |
| 17. INFORMANT
Amy R. Ford | | Address
2 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC CARDIO-VASCULAR DIS.
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <input type="checkbox"/> DUE TO (c) <input type="checkbox"/> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. <input type="checkbox"/> p. m. <input type="checkbox"/> 19 <input type="checkbox"/> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Jan. 3, 1960, to 11 JAN , 1960, that I last saw the deceased alive on 10 JAN , 1960, and that death occurred at 8:10 A.M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 11 Southgate Ave., DATE SIGNED
ACTUAL SIGNATURE Edward S. Beck M.D.
PHYSICIAN'S NAME (Type) Edward S. Beck Annapolis, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
1-14-1960 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Cedar Bluff | | 22d. LOCATION (City, town, or county) (State)
Annapolis Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John H. Taylor & Sons | | 24a. REC'D BY REGISTRAR
DATE JAN 14 '60 | |
| ADDRESS
Annapolis, Md. | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Hume | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00133

0154

| | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY
Anne Arundel | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Laurel, Md. | | c. LENGTH OF STAY IN 1b
2 yr. 8 mo. | | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE
MARYLAND | | b. COUNTY
Washington, D.C. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
47x | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
District Training School, Center | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | d. STREET ADDRESS
211 F Street N.W. | | | | | | | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
Allan James Gatta | | 4. DATE OF DEATH
Month Day Year
January 25 1960 | | 5. SEX
male | | 6. COLOR OR RACE
white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
10/6/48 | |
| 9. AGE (In years last birthday) yrs
11 | | IF UNDER 1 YEAR
Months Days Hours Min.
11 | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
--- | | 10b. KIND OF BUSINESS OR INDUSTRY
--- | | 11. BIRTHPLACE (State or foreign country)
Washington, D.C. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Robert George Poddler | | 14. MOTHER'S MAIDEN NAME
Dorothy Josephine Gatta | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
--- | | 16. SOCIAL SECURITY NO.
--- | | 17. INFORMANT
Social Service, Children's Center, Laurel, MD. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)
351x
DUE TO
Bronchopneumonia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
Cerebral Palsy - idiot level
DUE TO
(c)
Convulsive Disorders | | INTERVAL BETWEEN ONSET AND DEATH | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY
Month Day Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 7, 1957 to Jan. 25, 1960 , that I last saw the deceased alive on Jan. 25, 1960 , and that death occurred at 2:45 p. M. from the causes and on the date stated above. | | ADDRESS (Street, city or town, state)
Children's Center, Laurel, Md. | | DATE SIGNED
1/26/60 | | ACTUAL SIGNATURE
James E. Boyland M.D. | | PHYSICIAN'S NAME (Type)
James E. Boyland, M.D. | | LOCATION (City, town, or county) (State)
Washington D.C. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
1/29/60 | | 22c. NAME OF CEMETERY OR CREMATORY
Not Allevet | | 22d. LOCATION (City, town, or county) (State)
Washington D.C. | | 23. FUNERAL DIRECTOR'S SIGNATURE
W. L. Chas. ... | | ADDRESS
Not Allevet | |
| 24a. REC'D BY REGISTRAR
DATE JAN 29 '60 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus | | | | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

00134

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Anne Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gambells</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Gambells</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS <u>Box 574</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Eliza Ellen Greenleaf</u> | | 4. DATE OF DEATH <u>January 15 1960</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>C</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1-5-1897</u> |
| 9. AGE (In years last birthday) <u>63</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Joseph Carr</u> | | 14. MOTHER'S MAIDEN NAME <u>Sarah Bester</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>—</u> | |
| 17. INFORMANT <u>Martha Jenkins</u> | | Address <u>Hamtills Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinomatosis</u>
<u>156.1</u> DUE TO <u>Carcinoma Liver</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u>
(c) <u>—</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>10 months</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>September 1957</u> to <u>this date</u> , that I last saw the deceased alive on <u>1-15</u> , 19 <u>60</u> , and that death occurred at <u>1 P.</u> M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Febus Greenberg</u> M.D. | | ADDRESS (Street, city or town, state) <u>P.O. Box 57</u> DATE SIGNED <u>1-15-60</u> | |
| PHYSICIAN'S NAME (Type) <u>Febus Greenberg</u> | | <u>Caputen Md</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>1-19-1960</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Wilson Memorial Mt. Sator Md.</u> | 22d. LOCATION (City, town, or county) (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese</u> ADDRESS <u>Annapolis Md</u> | | 24a. REC'D BY REGISTRAR <u>—</u> DATE <u>JAN 19 60</u> | 24b. REGISTRAR'S SIGNATURE <u>—</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



0125 CERTIFICATE OF DEATH

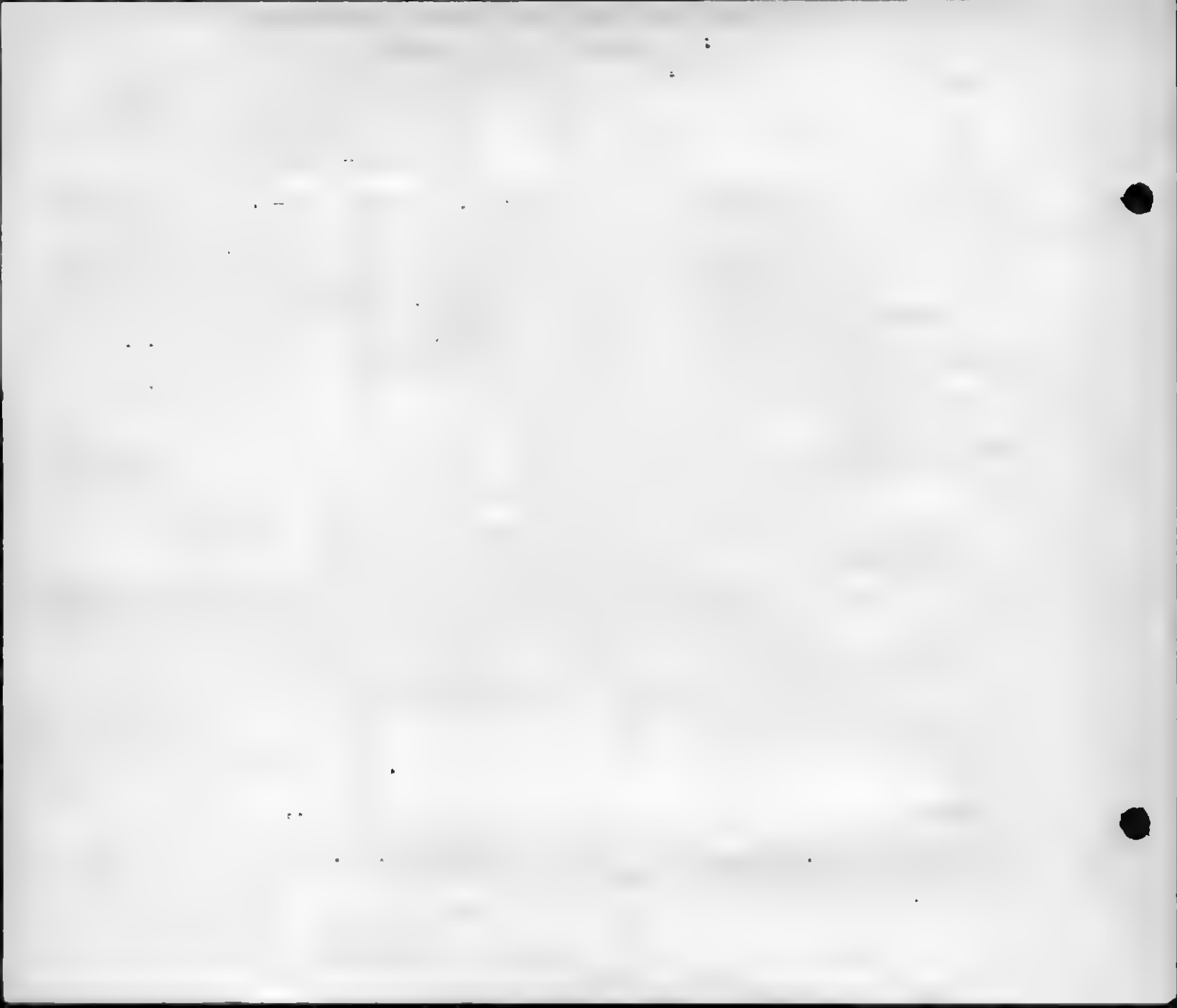
Reg. Dist. No.

00135

| | | | | | | | |
|--|----------------------------------|---|--------------------------------------|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
b. STATE Maryland b. COUNTY Anne Arundel | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Annapolis | | | | c. LENGTH OF STAY IN 1b
1 day | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Anne Arundel General Hospital | | | | d. STREET ADDRESS
9th St. Box-506, Rt-3. | | | |
| 3. NAME OF DECEASED (Type or print) Frank Paul First Middle Last | | | | 4. DATE OF DEATH
Month January Day 27 Year 1960 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
July 1899 | 9. AGE (In years last birthday)
60 yrs. | IF UNDER 1 YEAR
Months Days Hours Min | IF UNDER 24 HRS.
Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Town Director | | | | 10b. KIND OF BUSINESS OR INDUSTRY
W. A. C. Williams | | 11. BIRTH PLACE (State or foreign country)
Connecticut Hartford | |
| 13. FATHER'S NAME
George F. Griffin | | | | 14. MOTHER'S MARRIAGE NAME
Mary Phillips | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or date of service) | | | | 16. SOCIAL SECURITY NO.
216-01-3513 | | 17. INFORMANT
Cedric E. Griffin Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Asil pneumonia & edema
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial infarction post.
DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
36 hr.
" (?) | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED
White <input type="checkbox"/> Not white <input type="checkbox"/>
of work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from 1-26-60 to 1-27-60 , that I last saw the deceased alive on 1-27-60 , and that death occurred at 3:15 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Frank M. Shipley | | | | ADDRESS (Street, city or town, state) 121 Cathedral St., DATE SIGNED 1/27/60 | | | |
| PHYSICIAN'S NAME (Type) Frank M. Shipley | | | | Annapolis, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| Burial | | Jan 30 -60 | | Holy Cross Cemetery | | Pitters Highway Annapolis | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
James A. Fink | | | | ADDRESS
John Burns Rd | | 24a. REC'D BY REGISTRAR
DATE JAN 29 '60 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kious | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

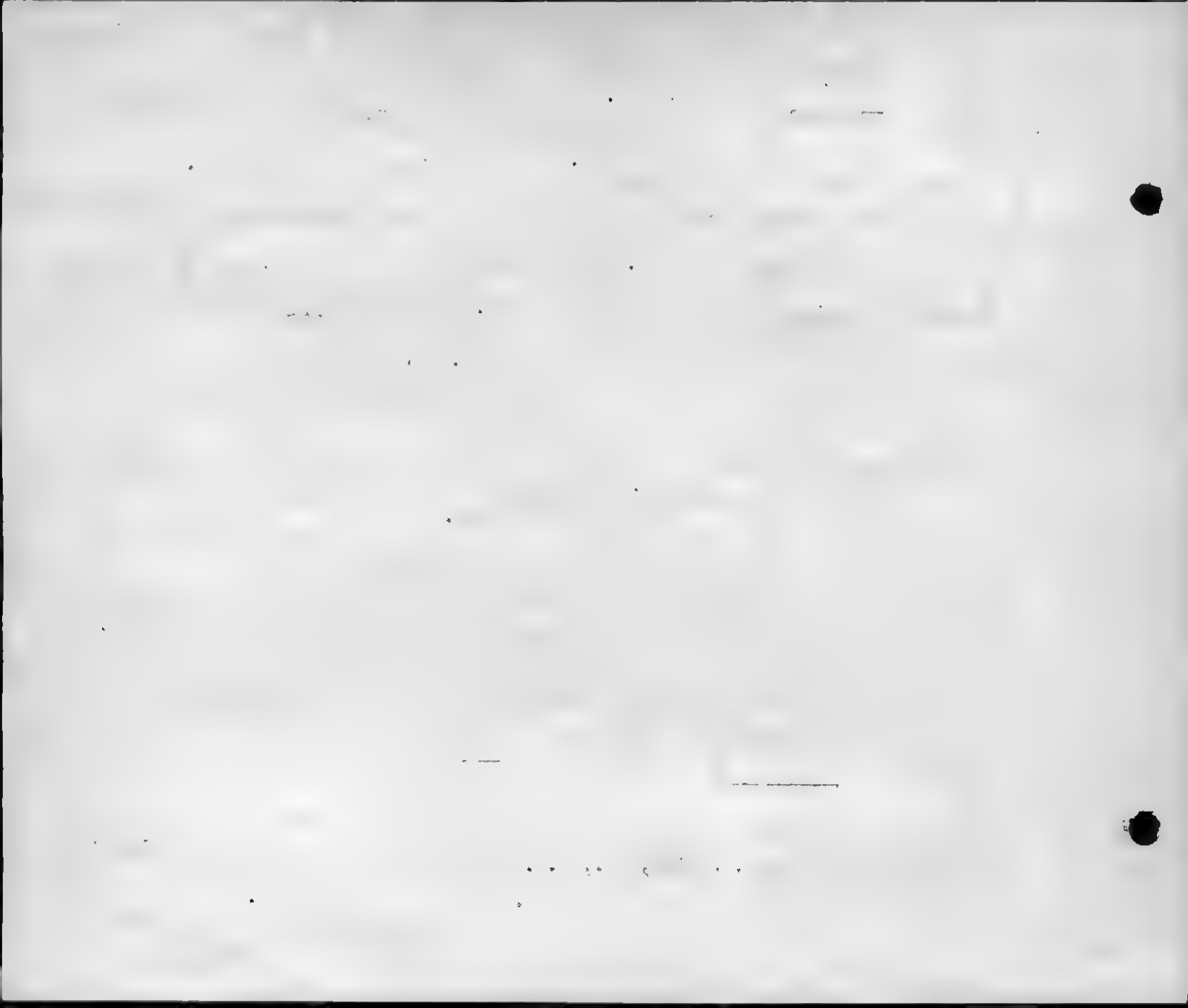
VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00136

| | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|---|--|--|--|---|--|--|--|--|--|--|--|---|--|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Baltimore | | b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Brooklyn Park | | c. LENGTH OF STAY IN Yrs. | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland | | b. COUNTY Baltimore | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore (Brooklyn Pk.) | | d. STREET ADDRESS 5802 Redman Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
ANNA L. GULICK | | 4. DATE OF DEATH
January 25 19 60 | | 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Aug. 16, 1882 | | 9. AGE (In years last birthday) 77 yrs | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | | | | | | |
| 11. BIRTHPLACE (State or foreign country) W. Va. | | 12. CITIZEN OF WHAT COUNTRY? | | 13. FATHER'S NAME Vincent Topper | | 14. MOTHER'S MAIDEN NAME ? | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Family | | Address Same | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
420.1 DUE TO Coronary Occlusion.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO
(c)
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Partial | | | | 20f. (City or town) (County) (State) | | | | | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE William V. Lovitt, Jr. | | | | M.D. William V. Lovitt, Jr., M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | DATE SIGNED 1/26/60 | | | |
| EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D. | | | | Address (Street, city, town, or county) | | | | 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 22b. DATE THEREOF 1/30/60 | | | | 22c. NAME OF CEMETERY OR CREMATORY Ebenezer Cem. | | | | 22d. LOCATION (City, town, or county) (State) Romney W. Va. | | | |
| 23. FUNERAL DIRECTOR McCully Funeral Homes | | | | ADDRESS 130 E. Fort Ave. # 30 | | | | 24a. REC'D BY REGISTRAR JAN 28 '60 | | | | 24b. REGISTRAR'S SIGNATURE Arthur L. Kraus | | | | | | | | | | | |



TO HOSPITAL: The attending physician: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00137

.0157

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>AA</u>
<u>MARYLAND</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE <u>MD</u>
b. COUNTY <u>aa</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Brooklyn PK</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>50 Brooklyn</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>321, Home PK Rd.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Brian C. Hammel</u>
First Middle Last | | 4. DATE OF DEATH
Month <u>1</u> Day <u>29</u> Year <u>1960</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>12-3-59</u> |
| 9. AGE (In years last birthday) <u>0 weeks</u> | | 10. IF UNDER 1 YEAR Days <u>0</u> Hours <u>0</u> Min <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>child</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>none</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>MD, Baltimore City</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
<u>Geo S. Hammel</u> | | 14. MOTHER'S MAIDEN NAME
<u>Jean Ogle Edie</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>-</u> | |
| 17. INFORMANT
<u>Family same</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>475x Acute Upper Respiratory Infection</u>
DUE TO (b) _____
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) _____
DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____
INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. _____ p. m. _____ | 20d. INJURY OCCURRED While <input type="checkbox"/> of work _____ Not while <input type="checkbox"/> of work _____ | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) _____ (County) _____ (State) _____ |
| 21. I certify that I attended the deceased from <u>Dec. 11, 1959</u> to <u>Jan 26, 1960</u> , that I last saw the deceased alive on <u>Jan 26, 1960</u> , and that death occurred at _____ M, from the causes and on the date stated above | | | |
| ACTUAL SIGNATURE <u>P. J. Grimaldi</u> | | ADDRESS (Street, city or town, state) <u>4609 Gov. Ritchie Hwy Baltimore Md</u> | |
| PHYSICIAN'S NAME (Type) <u>P. J. GRIMALDI</u> | | DATE SIGNED <u>1-29-60</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>burial</u> | 22b. DATE THEREOF
<u>1-30-60</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>Green Haven</u> | 22d. LOCATION (City, town, or county) <u>Green Burnside Md</u> (State) _____ |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>McCully Funeral Home</u> | | 24a. REC'D BY REGISTRAR
DATE <u>FEB 1 '60</u> | |
| ADDRESS <u>130 C Foxe</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Harris</u> | |

7263 XV6



0158
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|---|---|---|
| 1 PLACE OF DEATH
a. COUNTY <i>Anne Arundel</i> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <i>Bayside Beach</i> b. COUNTY <i>Anne Arundel</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Rural Pasadena, Md.</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Rural Pasadena, Md.</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
<i>Charles Benjamin Hardesty</i> | | 4. DATE OF DEATH
Month Day Year
<i>January 20 1960</i> | |
| 5. SEX
<i>Male</i> | 6. COLOR OR RACE
<i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>November 5, 1880</i> |
| 9. AGE (In years last birthday)
<i>79</i> yrs | | 10. IF UNDER 1 YEAR
Months Days Hours Min | 11. IF UNDER 24 HRS
Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Railroad clerk</i> | | 10b. KIND OF BUSINESS OR INDUSTRY
<i>Railroad</i> | 11. BIRTHPLACE (State or foreign country)
<i>Maryland</i> |
| 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.</i> | | 13. FATHER'S NAME
<i>Benjamin C. Hardesty</i> | |
| 14. MOTHER'S MAIDEN NAME
<i>Elizabeth Cox</i> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <i>No</i> | |
| 16. SOCIAL SECURITY NO.
<i>705-05-7807</i> | | 17. INFORMANT
Address
<i>MRS Carrie Hardesty Pasadena, Md.</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Carcinoma of the lung</i>
<i>163X</i> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>none</i> | | | INTERVAL BETWEEN ONSET AND DEATH
<i>1 year</i> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
<i>19</i> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <i>May 15, 1959</i> , to <i>Jan. 20, 1960</i> , that I last saw the deceased alive on <i>Jan. 19, 1960</i> , and that death occurred at <i>4:55 A.M.</i> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>R. M. McLaughlin</i> | | ADDRESS (Street, city or town, state) DATE SIGNED
<i>RFD 8 Box 442 Pasadena, Md. Jan. 20 1960</i> | |
| PHYSICIAN'S NAME (Type) <i>R. M. McLaughlin</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | 22b. DATE THEREOF
<i>23 Jan '60</i> | 22c. NAME OF CEMETERY OR CREMATORY
<i>Woodlawn</i> | 22d. LOCATION (City, town, or county) (State)
<i>Woodlawn, Md.</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<i>H. V. Singleton</i> | | ADDRESS
<i>Glen Burnie Md.</i> | 24a. REC'D BY REGISTRAR
DATE <i>JAN 22 '60</i> |
| | | 24b. REGISTRAR'S SIGNATURE
<i>Arthur S. Thomas</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

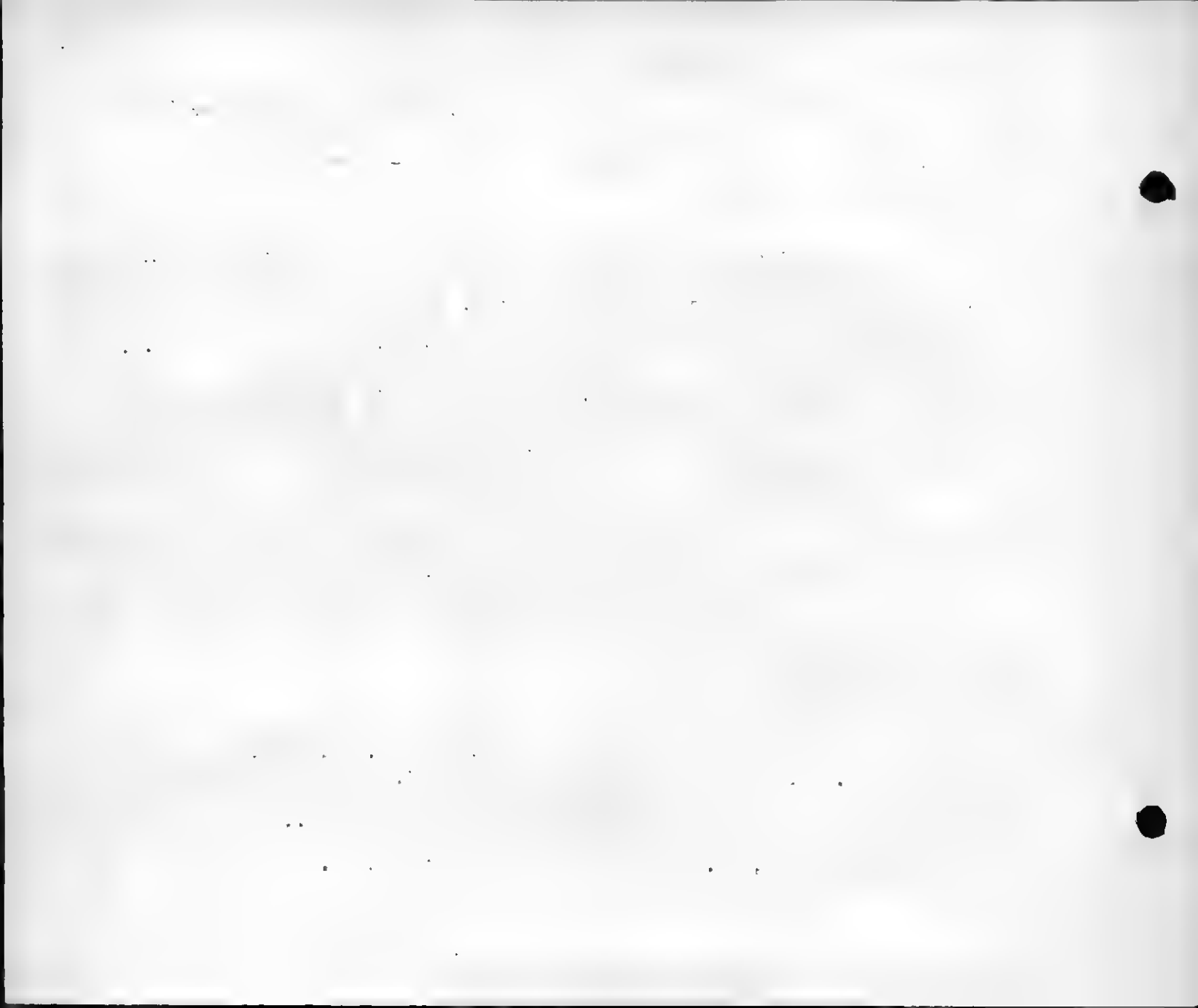
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



0126 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Annapolis | | c. LENGTH OF STAY IN 1b
12 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Anne Arundel General Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Julius Middle WALTER Last HARDESTY | | 4. DATE OF DEATH
Month January Day 20 Year 1960 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
June 9, 1877 |
| 9. AGE (In years last birthday)
82 yrs | | 10. IF UNDER 1 YEAR
Months 82 Days 0 Hours 0 Min. 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
FARMER | | 10b. KIND OF BUSINESS OR INDUSTRY
RETIRED | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
JAMES DANIEL HARDESTY | | 14. MOTHER'S MAIDEN NAME
MARY E. HARDESTY | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. INFORMANT
RICHARD WARD Lothian, Md | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 600.0 DUE TO Memoria
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Pneumonia, bilat DUE TO 1 wk.
(c) 1 wk. | | INTERVAL BETWEEN ONSET AND DEATH
1 wk. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from January 8, 1959 , to Jan. 20, 1960 , that I last saw the deceased alive on Jan. 20, 1960 , and that death occurred at 7:40 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Edwin Davis, Jr. M.D. | | ADDRESS (Street, city or town, state) 98 Cathedral St., Annapolis, Md. | |
| PHYSICIAN'S NAME (Type) Edwin Davis, Jr. | | DATE SIGNED 1/21/60 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
1/23/60 | |
| 22c. NAME OF CEMETERY OR CREMATORY
QUAKER | | 22d. LOCATION (City, town, or county) (State)
GALESVILLE, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Bernard W. Hardesty | | 24a. REC'D BY REGISTRAR
JAN 25 '60 | |
| ADDRESS
Galesville, Md. | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Frank | |



FOR STATE
HEALTH REPORT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00140

1. PLACE OF DEATH 0159
a. COUNTY Anne Arundel MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Laurel
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Laurel Race Track Road

2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)
a. STATE Maryland b. COUNTY Howard
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Scaggsville
d. STREET ADDRESS Rt. 1, Box 283

3. NAME OF DECEASED (Type or print) Esther Geraldine Harding
4. DATE OF DEATH January 21 19 60
5. SEX Female 6. COLOR OR RACE White 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH 7-19-15
9. AGE (In years last birthday) 44 yrs. 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) New York State
12. CITIZEN OF WHAT COUNTRY U. S. A.

13. FATHER'S NAME Charles Ginsberg
14. MOTHER'S MAIDEN NAME Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
16. SOCIAL SECURITY NO. 17. INFORMANT Mr. Joseph Daniel Harding (Husband) Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Multiple traumatic injuries
812x DUE TO
Conditions, if any, which gave rise to immediate cause (b)
(a), stating the underlying cause last. DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a 19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck by car while lying in road
20c. TIME OF INJURY Month, Day, Year 12:15xx 1/21 19 60
20d. INJURY OCCURRED While ☐ Not While ☒ el work
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Road
20f. (City or town) Laurel, Anne Arundel Co., Md. (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE William V. Hardy M.D.
EXAMINER'S NAME (Type) DATE SIGNED Jan. 21, 1960
DEPUTY MEDICAL EXAMINER ☐ Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 1/22/60
22c. NAME OF CEMETERY OR CREMATORY Emmanuel Cem.
22d. LOCATION (City, town, or country) Scaggsville Md. (State)

23. FUNERAL DIRECTOR De Witt Sanddean, Laurel, Md. ADDRESS
24a. REC'D BY REG STRA 24b. REGISTRAR'S SIGNATURE
DATE JAN 26 '60 Arthur S. Kraus

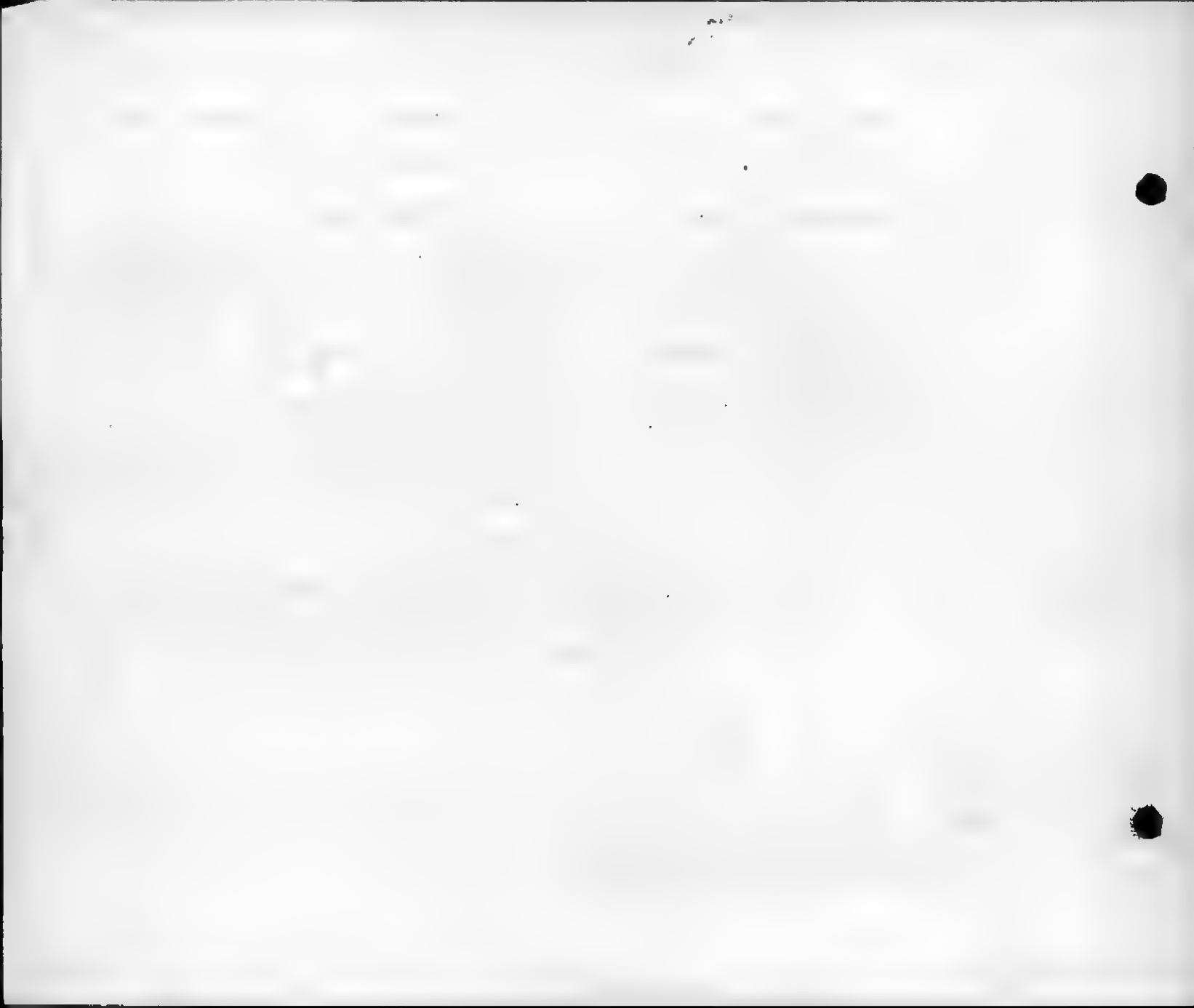


0127 CERTIFICATE OF DEATH

Reg. Dist. No.

00141

| | | | | | | | |
|--|-------------------------------|--|----------------------------------|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis, Md. | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital | | | | d. STREET ADDRESS 201 Woods Drive | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Anna Middle H Last Harnish | | | | 4. DATE OF DEATH
Month January Day 29 Year 19 60 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 11/13/89 | 9. AGE (In years lost birthday) 70 yrs. | IF UNDER 1 YEAR
Months 70 Days 70 Hours 70 Min 70 | IF UNDER 24 HRS
Months 70 Days 70 Hours 70 Min 70 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (State or foreign country) Williamsburg Pa | | 12. CITIZEN OF WHAT COUNTRY? U. S. A | |
| 13. FATHER'S NAME George Humphrey | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — | | 16. SOCIAL SECURITY NO. — | | INFORMANT Robert Q. Harnish Address (2) | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 331X DUE TO CEREBRAL HEMORRHAGE OR ANOXIA
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIO SCLEROSIS DUE TO (c) PYLORIC STENOSIS CARCINOMA FROM LEFT Breast | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) — | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from 1-22- 19 60 to 1-29- 19 60 , that I last saw the deceased alive on 1-29- 19 60 , and that death occurred at 5 P. M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE Jesse L. Wilkins M.D. | | | | ADDRESS (Street, city or town, state) 98 Cathedral St. Annapolis, Md. | | | |
| PHYSICIAN'S NAME (Type) JESSE L. WILKINS | | | | DATE SIGNED 1/30/60 | | | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 2-2-1960 | | 22c. NAME OF CEMETERY OR CREMATORY Highland Cemetery | | 22d. LOCATION (City, town, or county) (State) Lock Haven Pa | |
| 23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons ADDRESS Annapolis Md | | | | 24a. REC'D BY REGISTRAR FEB 2 '60 | | 24b. REGISTRAR'S SIGNATURE Arthur L. Hines | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00142

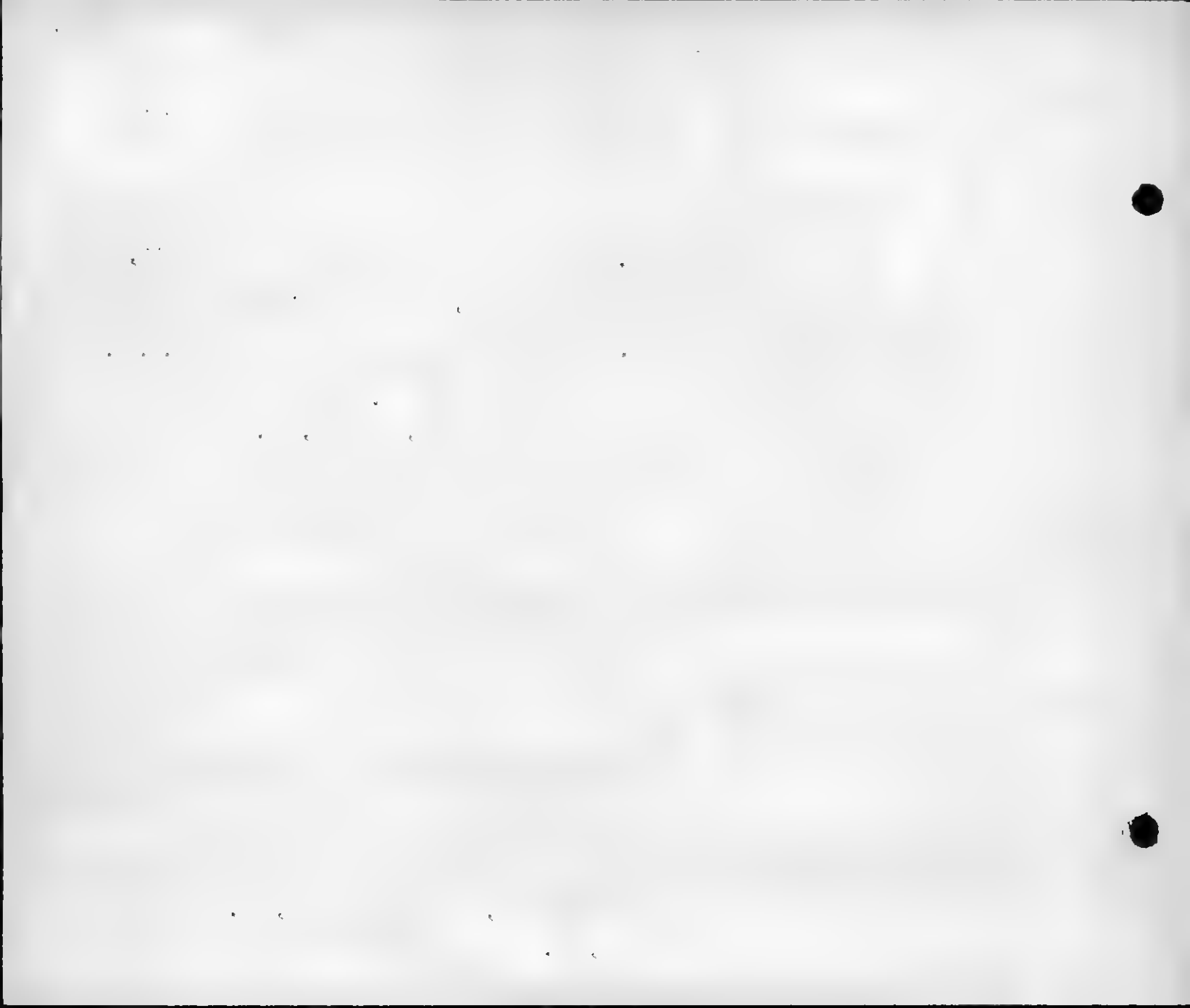
0160

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Jessup
c. LENGTH OF STAY IN 1b
40 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE
Maryland
b. COUNTY
Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Jessup
d. STREET ADDRESS

e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First
MARY
Middle
E.
Last
HEBRON | | | | 4. DATE OF DEATH
Month
Jan.
Day
11,
Year
1960 | | | |
| 5. SEX
female | | 6. COLOR OR RACE
colored | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
April 6, 1895 | |
| 9. AGE (In years last birthday)
64 yrs. | | IF UNDER 1 YEAR
Months
Days
Hours
Min | | IF UNDER 24 HRS.
Months
Days
Hours
Min | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laundress | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Govt. | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S. A. | | | | | | | |
| 13. FATHER'S NAME
Nathaniel Washington | | | | 14. MOTHER'S MAIDEN NAME
Winnie A. Dorsey | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO | | 17. INFORMANT
Ellen Allen, Jessup, Md. Address
(Sister) | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and, (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma metastatic
153.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) C.A. Cancer DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
16 mo - | | | | | | INTERVAL BETWEEN ONSET AND DEATH
16 mo - | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 12/23, 1958 to 1/11, 1960 , that I last saw the deceased alive on 1/11, 1960 , and that death occurred at 10:55 P.M. from the causes and on the date stated above
ADDRESS (Street, city or town, state)
DATE SIGNED 1/1/60 | | | | | | | |
| ACTUAL SIGNATURE B. P. Warren M.D. | | | | PHYSICIAN'S NAME (Type)
B. P. WARREN | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
1/15/60 | | 22c. NAME OF CEMETERY OR CREMATORY
Church Cemetery, | | 22d. LOCATION (City, town, or county) (State)
Jessup, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Robert L. Snowden ADDRESS
Rockville, Md. | | | | 24a. REC'D BY REGISTRAR
DATE
Jan 18 '60 | | 24b. REGISTRAR'S SIGNATURE
William S. Hume | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



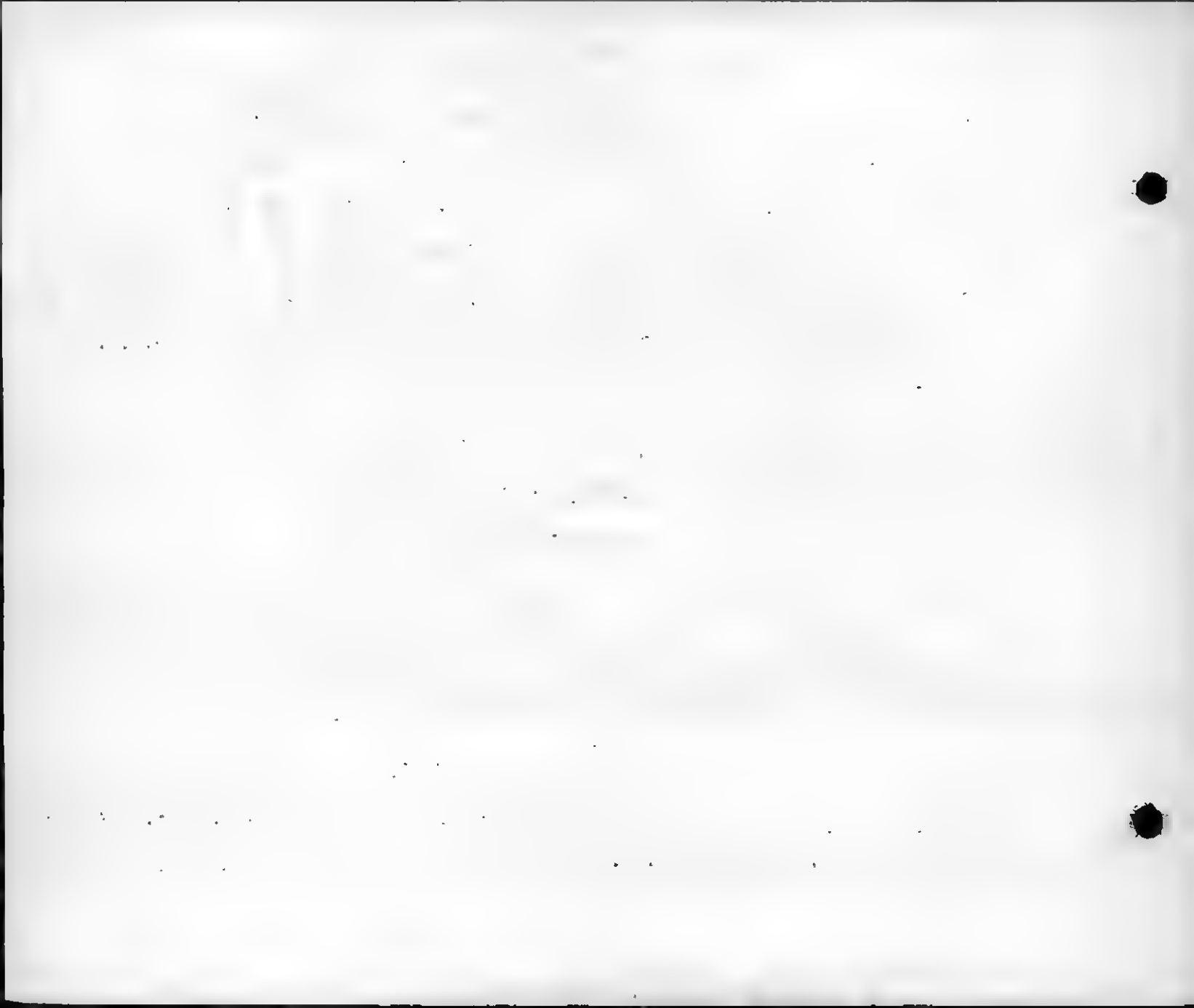
00143

TO HOSPITAL CONSULTING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
ISM 9/SB

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY
<div style="border: 1px solid black; padding: 2px;">Anne Arundel</div> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
<div style="border: 1px solid black; padding: 2px;">Maryland</div> b. COUNTY
<div style="border: 1px solid black; padding: 2px;">Baltimore City</div> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<div style="border: 1px solid black; padding: 2px;">Crownsville</div> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<div style="border: 1px solid black; padding: 2px;">Baltimore</div> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION
<div style="border: 1px solid black; padding: 2px;">Crownsville State Hospital</div> | | d. STREET ADDRESS
<div style="border: 1px solid black; padding: 2px;">542 N. Carrollton Avenue</div> | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
<div style="display: flex; justify-content: space-between;"> <div>First
Phillip</div> <div>Middle
Lee</div> <div>Last
Holly</div> </div> | | | |
| 4. DATE OF DEATH
Month: 1, Day: 19, Year: 1960 | | | |
| 5. SEX
<div style="border: 1px solid black; padding: 2px;">Male</div> | | 6. COLOR OR RACE
<div style="border: 1px solid black; padding: 2px;">Negro</div> | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<div style="border: 1px solid black; padding: 2px;">1936</div> | |
| 9. AGE (In years last birthday)
<div style="border: 1px solid black; padding: 2px;">24</div> | | 10. IF UNDER 1 YEAR
Months: , Days: , Hours: , Min: | |
| 11. IF UNDER 24 HRS
Months: , Days: , Hours: , Min: | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<div style="border: 1px solid black; padding: 2px;">Unknown</div> | | 10b. KIND OF BUSINESS OR INDUSTRY
<div style="border: 1px solid black; padding: 2px;">-----</div> | |
| 11. BIRTHPLACE (State or foreign country)
<div style="border: 1px solid black; padding: 2px;">Unknown</div> | | 12. CITIZEN OF WHAT COUNTRY?
<div style="border: 1px solid black; padding: 2px;">U.S.A.</div> | |
| 13. FATHER'S NAME
<div style="border: 1px solid black; padding: 2px;">Unknown</div> | | 14. MOTHER'S MAIDEN NAME
<div style="border: 1px solid black; padding: 2px;">Unknown</div> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown)
<div style="border: 1px solid black; padding: 2px;">Unknown</div> | | 16. SOCIAL SECURITY NO.
<div style="border: 1px solid black; padding: 2px;">Unknown</div> | |
| 17. INFORMANT
<div style="border: 1px solid black; padding: 2px;">Hospital Records</div> | | Address
 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
<div style="border: 1px solid black; padding: 5px;"> PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) <u>Cerebral Edema</u>
 300.2 DUE TO
 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Schizophrenia, Catatonic Type</u>
 DUE TO (c) _____ </div> | | | |
| INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
<div style="border: 1px solid black; padding: 2px;">-----</div> | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. - - - 19 -
p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<div style="border: 1px solid black; padding: 2px;">-----</div> | | 20f. (City or town) (County) (State)
<div style="border: 1px solid black; padding: 2px;">-----</div> | |
| 21. I certify that I attended the deceased from 1/6, 1960, to 1/19, 1960, that I last saw the deceased alive on 1/19, 1960, and that death occurred at 12:45 PM, from the causes and on the date stated above.
<div style="display: flex; justify-content: space-between;"> <div> ACTUAL SIGNATURE <u>Carl B. Schleifer</u>
 PHYSICIAN'S NAME (Type) Carl B. Schleifer, M.D. </div> <div> ADDRESS (Street, city or town, state)
 Crownsville State Hospital, Md. </div> <div> DATE SIGNED
 1/19/60 </div> </div> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<div style="border: 1px solid black; padding: 2px;">Burial</div> | | | |
| 22b. DATE THEREOF
<div style="border: 1px solid black; padding: 2px;">1-23-60</div> | | 22c. NAME OF CEMETERY OR CREMATORY
<div style="border: 1px solid black; padding: 2px;">Arbutus Mem. Cem.</div> | |
| 22d. LOCATION (City, town, or county) (State)
<div style="border: 1px solid black; padding: 2px;">Arbutus, Maryland</div> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<div style="border: 1px solid black; padding: 2px;">William A. Jackson, Inc.</div> | | 24. RECORD BY REGISTRAR
DATE JAN 25 1960 | |
| 24b. REGISTRAR'S SIGNATURE
<div style="border: 1px solid black; padding: 2px;">Arthur L. Hines</div> | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1, 8, 11, 12, 25, 4, 1-14-70 et

CERTIFICATE OF DEATH

Reg. Dist. No.

00144

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH
o COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
o Box 299, Millersville COUNTY Anne Arundel | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Millersville | | | | c. LENGTH OF STAY IN TB
64 years | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION
Sanns Nursing Home | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Millersville | | | |
| f. STREET ADDRESS
Jumper Hole Rd., Box 299, Millersville | | | | g. IS RESIDENCE ON A FARM?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 3. NAME OF DECEASED (Type or print)
First Ada Middle Irene Last HORKY | | | | 4. DATE OF DEATH
Month January Day 6 Year 1960 | | | |
| 5. SEX
F | | 6. COLOR OR RACE
white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
4-26-1896 1895 | |
| 9. AGE (In years last birthday)
64 yrs. | | 10. IF UNDER 1 YEAR
Months 6 Days 12 Hours 19 Min. | | 11. IF UNDER 24 HRS.
Months 6 Days 12 Hours 19 Min. | | 12. CITIZEN OF WHAT COUNTRY?
Yes | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Millersville, Md. | | | |
| 11. BIRTHPLACE (State or foreign country)
Millersville, Md. | | | | 12. CITIZEN OF WHAT COUNTRY?
Yes | | | |
| 13. FATHER'S NAME
Benjamin William DUVALL | | | | 14. MOTHER'S MAIDEN NAME
Sarah Johnson | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes no, or unknown) no (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO.
--- | | | |
| 17. INFORMANT
Address
daughter Mrs Dorothy Mace- Earleigh Heights, Severna Park, Maryland | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Nephritis - acute
DUE TO Diabetes
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Diabetes
DUE TO
(c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
cancer - left shldr. | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
No accident | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
No accident | | | |
| 20c. TIME OF INJURY
Hour o. m. 19
p. m. | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
--- | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from 7-9-1957 to 12-22-1959 , that I last saw the deceased alive on 12-22-1959 , and that death occurred at 230 P.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
H.F. Manuzak | | | | ADDRESS (Street, city or town, state)
Md. H. Burris, Md. | | | |
| DATE SIGNED
1-6-60 | | | | PHYSICIAN'S NAME (Type)
H.F. MANUZAK, M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
1-9-60 | | | | 22b. DATE THEREOF
1-9-60 | | | |
| 22c. NAME OF CEMETERY OR CREMATORY
Green Haven | | | | 22d. LOCATION (City, town, or county) (State)
MD 110. | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
M. E. Kelly - 130 E. Feet H.S. | | | | 24a. REC'D BY REGISTRAR
DATE JAN 8 '60 | | | |
| 24b. REGISTRAR'S SIGNATURE
Arthur L. Hume | | | | | | | |

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0163 CERTIFICATE OF DEATH

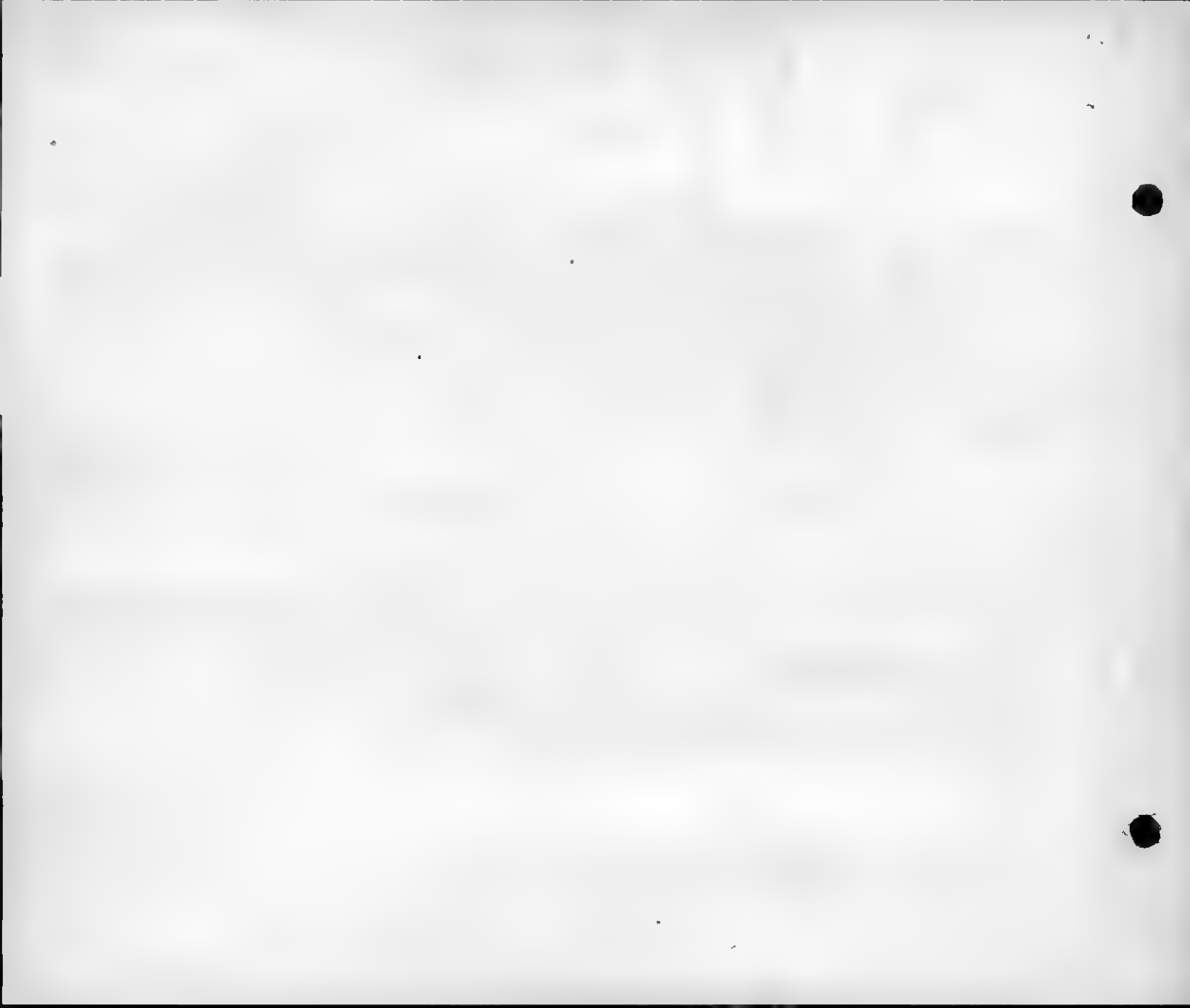
00145

Reg. Dist. No.

| | | | |
|--|------------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundal MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE Md. b. COUNTY Anne Arundal | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Glen Burnie | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Glen Burnie | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
100 Cherry Lane Road | | d. STREET ADDRESS
100 Cherry Lane Road | |
| 3. NAME OF DECEASED (Type or print)
Daniel Custer Hunt, Sr. | | 4. DATE OF DEATH
Month 1 Day 4 Year 1960 | |
| 5. SEX
Male | 6. COLOR OR RACE
Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
3-3-1878 |
| 9. AGE (In years lost birthday) 81 yrs. | | IF UNDER 1 YEAR: Months 1 Days 4 Hours 19 Min 60 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Insurance agent | | 10b. KIND OF BUSINESS OR INDUSTRY
Southern Life Co. | |
| 11. BIRTHPLACE (State or foreign country)
Va. | | 12. CITIZEN OF WHAT COUNTRY
U. S. A. | |
| 13. FATHER'S NAME
Daniel Custer Hunt | | 14. MOTHER'S MAIDEN NAME
Sallie Baker | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Dr. Richard Hunt | | Address
100 Cherry Lane Road | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 443X HYPERTENSIVE CARDIOVASCULAR DISEASE
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) 443X
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH
? |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from 12-1-1959 , to 1-4-1960 , that I last saw the deceased alive on 1-4-1960 , and that death occurred at M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 1824 W. Franklin St Balto DATE SIGNED 1-5-60 | | | |
| ACTUAL SIGNATURE Thomas W. Harris | | M.D. 1824 W. Franklin St Balto | |
| PHYSICIAN'S NAME (Type) Thomas W. Harris | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
B | 22b. DATE THEREOF
1-7-59 | 22c. NAME OF CEMETERY OR CREMATORY
MT. AUBURN | 22d. LOCATION (City, town, or county) (State)
Baltimore |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John M. Johnson-1700 Druid Hill Avenue | | 24a. REC'D BY REGISTRAR
JAN 6 '60 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur S. Kinney | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



0128 CERTIFICATE OF DEATH

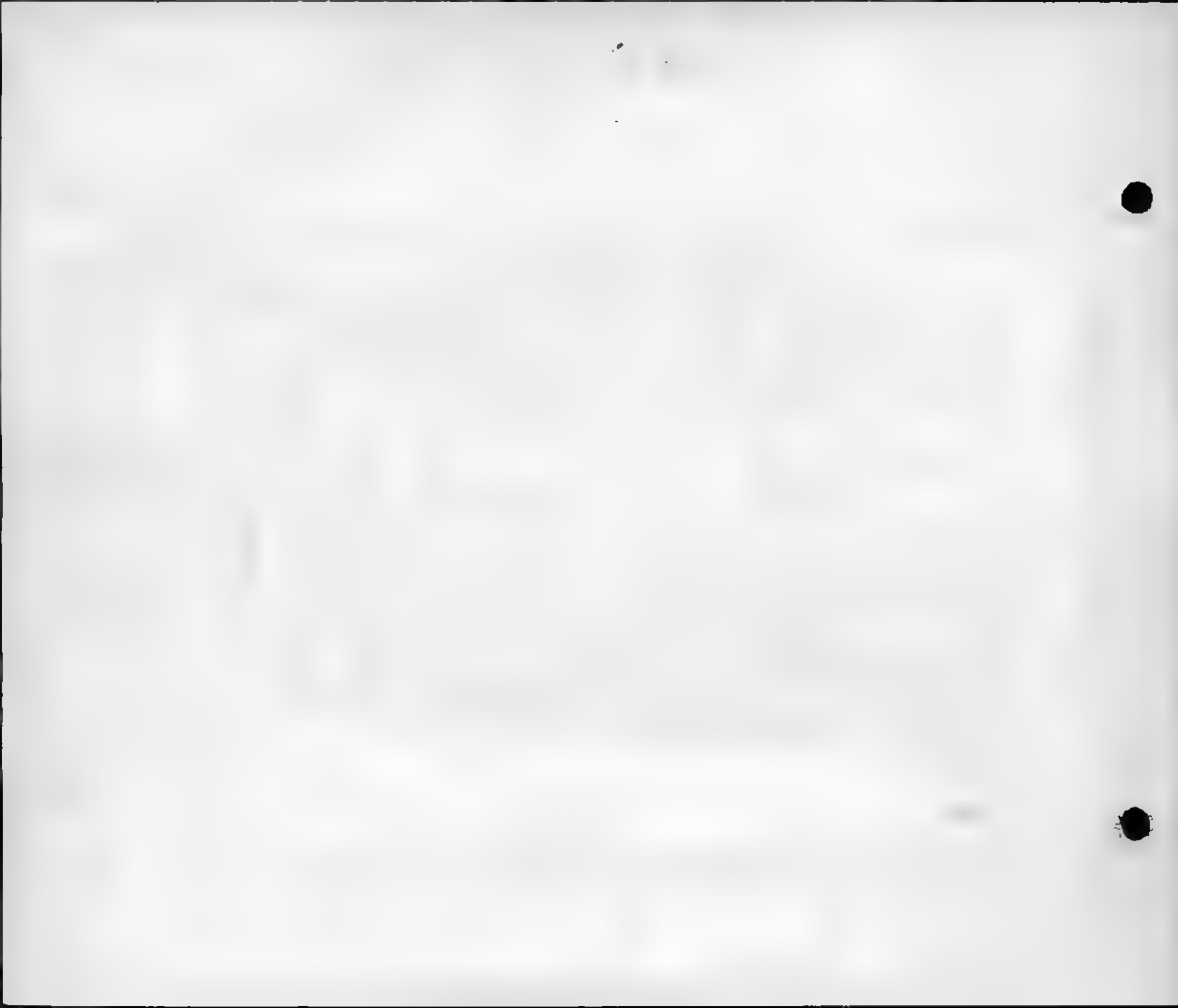
Reg. Dist. No.

00146

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY <i>AA</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <i>Md</i> b. COUNTY <i>AA</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Annapolis</i> | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<i>25 Franklin St</i> | | e. STREET ADDRESS
<i>25 Franklin St</i> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
<i>Blanche Bower Jackson</i> | | 4. DATE OF DEATH
Month Day Year
<i>1 - 4 1960</i> | |
| 5. SEX
<i>Female</i> | 6. COLOR OR RACE
<i>White</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>July 19th 1886</i> |
| 9. AGE (In years last birthday)
<i>73</i> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS
Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)
<i>House Wife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY
<i>Home</i> | |
| 11. BIRTHPLACE (State or foreign country)
<i>Hagerstown Md</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U. S. A</i> | |
| 13. FATHER'S NAME
<i>John Henry Bower</i> | | 14. MOTHER'S M maiden name
<i>Mary Elizabeth Suman</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<i>No</i> | | 16. SOCIAL SECURITY NO.
<i>-</i> | |
| 17. INFORMANT
<i>Elmer M Jackson Jr.</i> | | Address
<i>Wardour Annapolis Md</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Acute Congestive Cardiac Failure</i>
<i>57 x x</i> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Sub-Acute Myocarditis with Pulmonary Congestive</i>
DUE TO (c) <i>Chronic Nephritis</i> | | INTERVAL BETWEEN ONSET AND DEATH
<i>Several Months</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour a. m. p. m.
<i>19</i> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <i>9 - 12 - 1959</i> to <i>1 - 4 - 1960</i> , that I last saw the deceased alive on <i>12 - 15 - 1959</i> , and that death occurred at <i>7 A. M.</i> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
<i>J Oliver Purvis</i> | | ADDRESS (Street, city or town, state)
<i>40 French St., Annapolis, Md</i> | |
| PHYSICIAN'S NAME (Type)
<i>J Oliver Purvis</i> | | DATE SIGNED
<i>1/4/60</i> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 22b. DATE THEREOF
<i>1-6-60</i> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<i>St Annes Cent</i> | | 22d. LOCATION (City, town, or county) (State)
<i>Annapolis Md</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<i>John M. Taylor Sins</i> | | ADDRESS
<i>Annapolis Md</i> | |
| 24a. REC'D BY REGISTRAR
DATE
<i>JAN 7 '60</i> | | 24b. REGISTRAR'S SIGNATURE
<i>Arthur S. Sins</i> | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00147

0164

| | | | | | | | | | |
|--|--|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Anne Arundel | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Crownsville | | c. LENGTH OF STAY IN 1b
2mo. 7 days | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
Maryland | | b. COUNTY
Baltimore City | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Crownsville State Hospital | | | | d. STREET ADDRESS
1537 Ansor Street | | | | e. 15 RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) | | First
Annie | | Middle | | Last
Jefferson | | 4. DATE OF DEATH
Month
1
Day
25
Year
1960 | |
| 5. SEX
Female | | 6. COLOR OR RACE
Negro | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
1894 - Oct. 8 | | 9. AGE (In years last birthday)
65 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Unknown | | 10b. KIND OF BUSINESS OR INDUSTRY
Housewife | | 11. BIRTHPLACE (State or foreign country)
Unknown | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
Unknown | | 14. MOTHER'S MAIDEN NAME
Unknown | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service)
Unknown | | 16. SOCIAL SECURITY NO.
Unknown | | 17. INFORMANT
Hospital Records | |
| 18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a). Hypostatic Bronchopneumonia
420.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b). Myocardial-old and recent Infarction
DUE TO (c). Arteriosclerotic Cardiovascular + Renal Disease | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).
Cerebral Softening | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
----- | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. ----- 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
----- | | 20f. (City or town)
----- | | (County) (State) | |
| 21. I certify that I attended the deceased from 11/18 , 19 59 , to 1/25 , 19 60 , that I last saw the deceased alive on 1/25 , 19 60 , and that death occurred 11:30 A. M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
Hildegard Heard Reissman M.D. Crownsville State Hospital, Md. 1/25/60 | | | | | | | | | |
| ACTUAL SIGNATURE | | PHYSICIAN'S NAME (Type) Hildegard Heard Reissman Crownsville State Hospital, Md. 1/25/60 | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF
1-28-60 | | 22c. NAME OF CEMETERY OR CREMATORY
St. Anthony | | 22d. LOCATION (City, town, or county) (State)
Crownsville Md. | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Wm. Kelly Williams | | ADDRESS
323 P. D. Williams | | 24a. REC'D BY REGISTRAR
Wm. Kelly Williams | | 24b. REGISTRAR'S SIGNATURE
Charles E. Thomas | | DATE
JAN 29 1960 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Reg. Dist. No. 00148

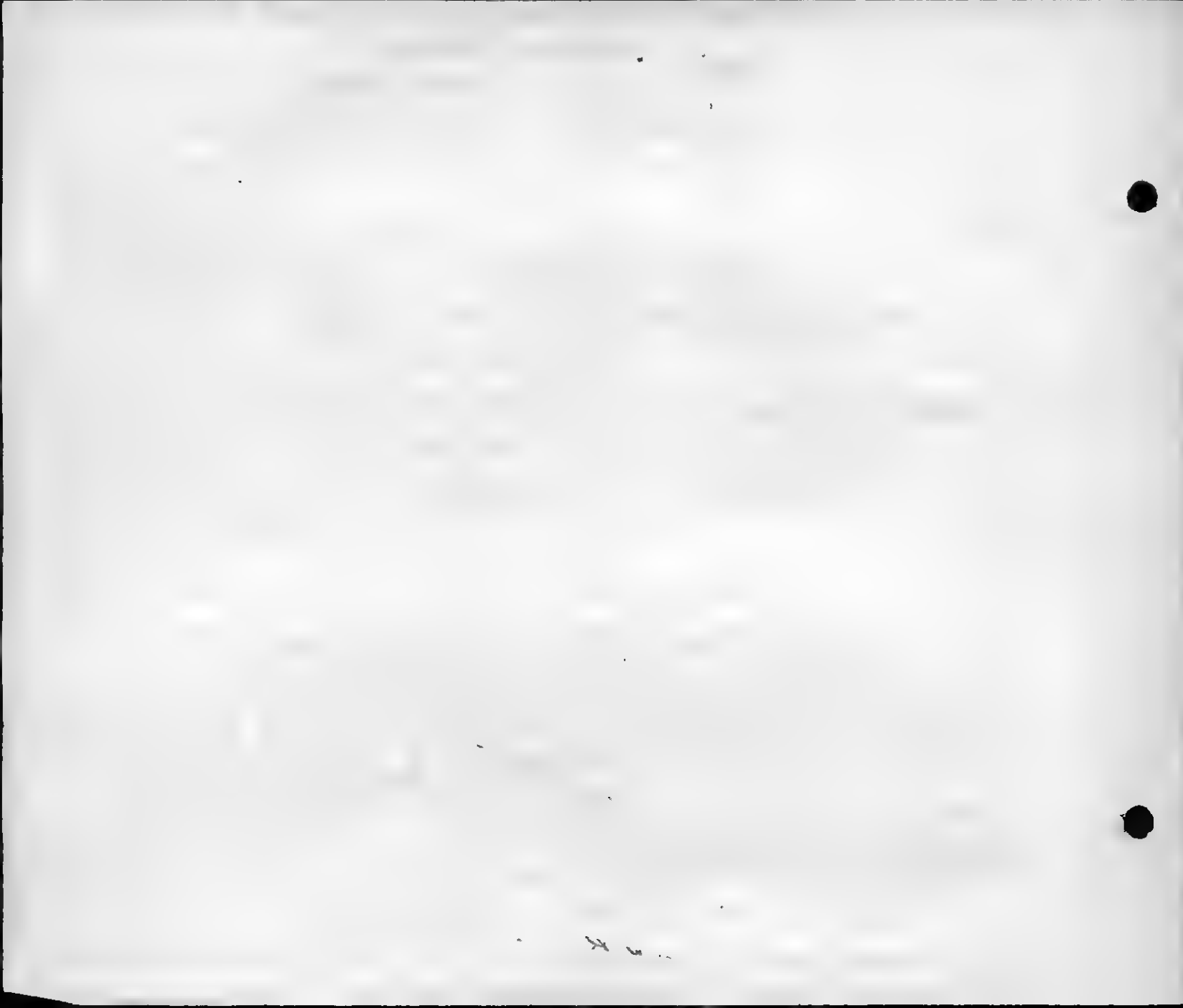
CERTIFICATE OF DEATH

Reg. Dist. No. 00148

| | | | |
|--|---------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Cumbe County</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>Cumbe County</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u> | | c. LENGTH OF STAY IN 1b <u>12 days</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Mary's Nursing Home</u> | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u> | |
| f. STREET ADDRESS <u>1000 N. Mill St.</u> | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>George</u> Middle <u>H.</u> Last <u>Johns</u> | | 4. DATE OF DEATH
Month <u>JAN</u> Day <u>16</u> Year <u>1960</u> | |
| 5. SEX <u>M.</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>March 14 1877</u> |
| 9. AGE (In years last birthday) <u>82</u> yrs. | | 10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GROCER-RETA</u> | | 11b. KIND OF BUSINESS OR INDUSTRY <u>Self-Employed</u> | |
| 12. BIRTHPLACE (State or foreign country) <u>PA</u> | | 13. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 14. FATHER'S NAME <u>Stephen Johns</u> | | 15. MOTHER'S MAIDEN NAME <u>Susan Miller</u> | |
| 16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 17. SOCIAL SECURITY NO. <u>196-01-5530</u> | |
| 18. INFORMANT <u>Ethel T. Luck</u> | | Address <u>Same as 2</u> | |
| 19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure -</u> | | | |
| 443X DUE TO <u>Senescent Hypertensive Cardiovascular Disease</u> | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Suprapubic Cystostomy -</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Suprapubic Cystostomy -</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>0</u> a. m. <u>19</u> p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>June 1954</u> to <u>January 16 1960</u> that I last saw the deceased alive on <u>1-12-60</u> and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above | | | |
| ACTUAL SIGNATURE <u>James Greenleaf</u> | | DATE SIGNED <u>1/16/60</u> | |
| PHYSICIAN'S NAME (Type) <u>Febus Greenleaf</u> | | ADDRESS (Street, city or town, state) <u>P.O. Box 97 Cumpton Md.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>1-19-60</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Forest Hill</u> | | 22d. LOCATION (City, town, or county) (State) <u>Dumore, Lacka Co. PA.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Herring & KIRKNEY</u> | | 24a. REC'D BY REGISTRAR <u>20 60</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00143

CERTIFICATE OF DEATH

Reg. Dist. No.

0166

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>A. A. County</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>A. A. County</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Matteson Hill</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS <u>R 404371 Anna, Md.</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>Mary A Johnson</u> First Middle Last | | 4. DATE OF DEATH
Month <u>1</u> Day <u>21</u> Year <u>1960</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Col</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10-16-1896</u> |
| 9. AGE (In years last birthday) <u>63</u> yrs | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Samuel L. Colbert</u> | | 14. MOTHER'S MAIDEN NAME <u>Catherine Walker</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Cesar Johnson R 404371 Anna, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>434.1</u> DUE TO <u>Congestive Cardiac Failure</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO _____
(c) DUE TO _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY
Month <u>1</u> Day <u>19</u> Year <u>1960</u>
Hour <u>8</u> a. m. p. m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) _____ (County) _____ (State) _____ |
| 21. I certify that I attended the deceased from <u>9-15</u> , 19 <u>59</u> , to <u>1-21-60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1-19-60</u> , 19 <u>60</u> , and that death occurred at <u>12:30</u> P. M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>G. J. CECOM</u> M.D. | | ADDRESS (Street, city or town, state) <u>62 Cecobol St</u> DATE SIGNED _____ | |
| PHYSICIAN'S NAME (Type) <u>A T ALLEN</u> | | Cemetary, Md. <u>_____</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>1-24-1960</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Broadneck</u> | 22d. LOCATION (City, town, or county) <u>A. A.</u> (State) <u>Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese Jr.</u> ADDRESS <u>Anna, Md.</u> | | 24a. REC'D BY REGISTRAR <u>_____</u> DATE <u>JAN 25 60</u> | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u> |

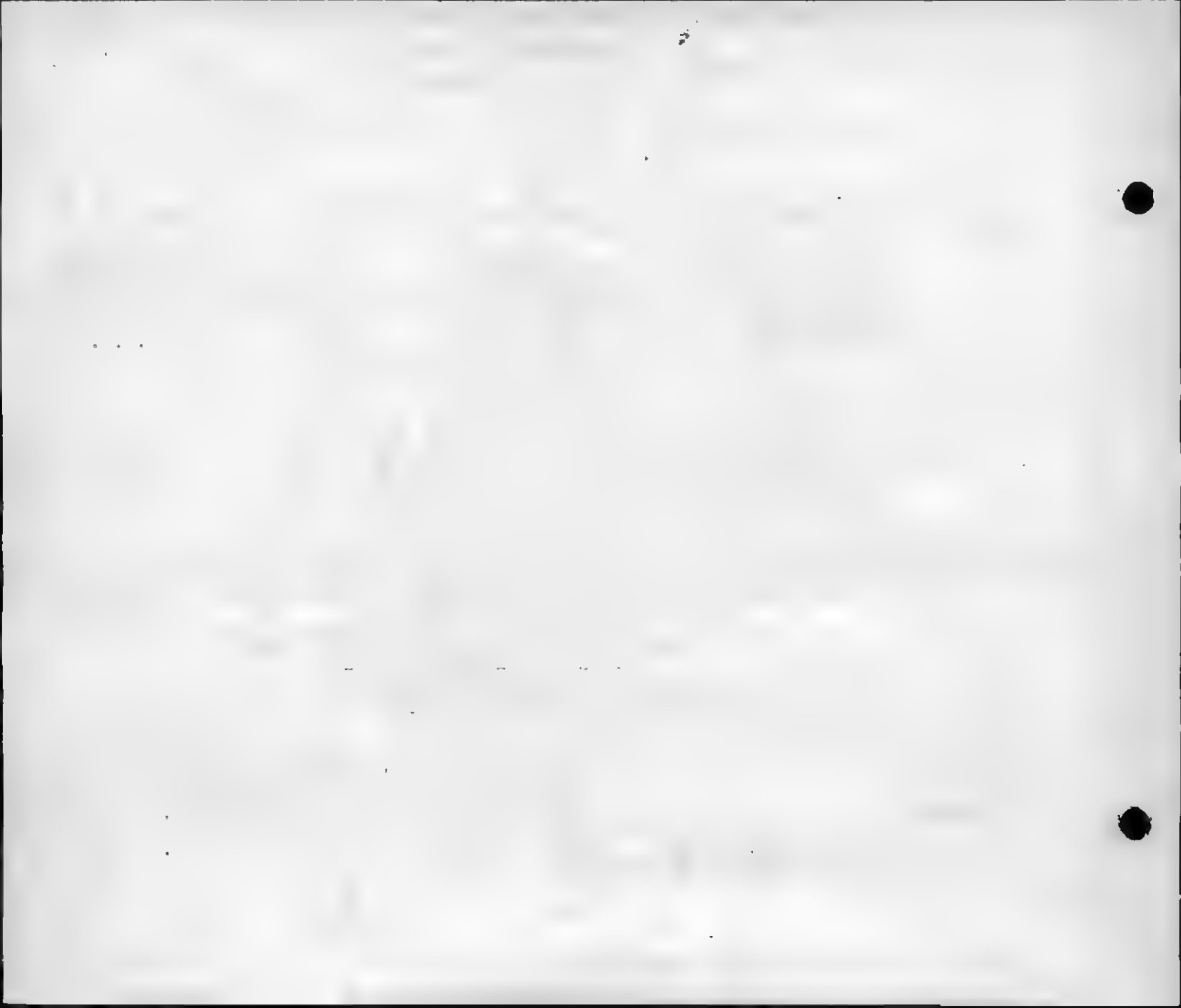


0167
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY
Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Crownsville
c. LENGTH OF STAY IN 1b
5mo. 13 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Crownsville State Hospital | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Anne Arundel
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
10 Annapolis
d. STREET ADDRESS
75 Pleasant Street
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Shirley Middle Johnson Last Johnson | | 4. DATE OF DEATH
Month 1 Day 26 Year 1960 | |
| 5. SEX
Male | 6. COLOR OR RACE
Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
February 24, 1884 |
| 9. AGE (In years lost birthday) yrs
75 | | IF UNDER 1 YEAR
Months 1 Days 26 Hours 19 Min 60 | IF UNDER 24 HRS
Months 1 Days 26 Hours 19 Min 60 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Unemployed | | 10b. KIND OF BUSINESS OR INDUSTRY
----- | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Unknown | | 14. MOTHER'S MAIDEN NAME
Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO
216-10-5872 | |
| 17. INFORMANT
Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia Hypostatic
422.1 DUE TO
Congestive Heart Failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Disease
DUE TO
(c) Arteriosclerotic Cardiovascular Disease | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
----- | |
| 20c. TIME OF INJURY
Hour o. m. 19
p. m. 19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
----- | 20f. (City or town) (County) (State)
----- |
| 21. I certify that I attended the deceased from 8/13 , 19 59 , to 1/26 , 19 60 , that I last saw the deceased alive on 1/26 , 19 60 , and that death occurred on 10:15 P.M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 1/27/60
ACTUAL SIGNATURE Lionel McHenry Mapp M.D. Crownsville State Hospital, Md. 1/27/60
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp Crownsville State Hospital, Md. 1/27/60 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
1-30-60 | 22c. NAME OF CEMETERY OR CREMATORY
St. Anns | 22d. LOCATION (City, town, or county) (State)
Baltimore Md |
| 23. FUNERAL DIRECTOR'S SIGNATURE
William Sease, Jr. | | 24a. REC'D BY REGISTRAR
DATE JAN 28 '60 | 24b. REGISTRAR'S SIGNATURE
Charles S. Thomas |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

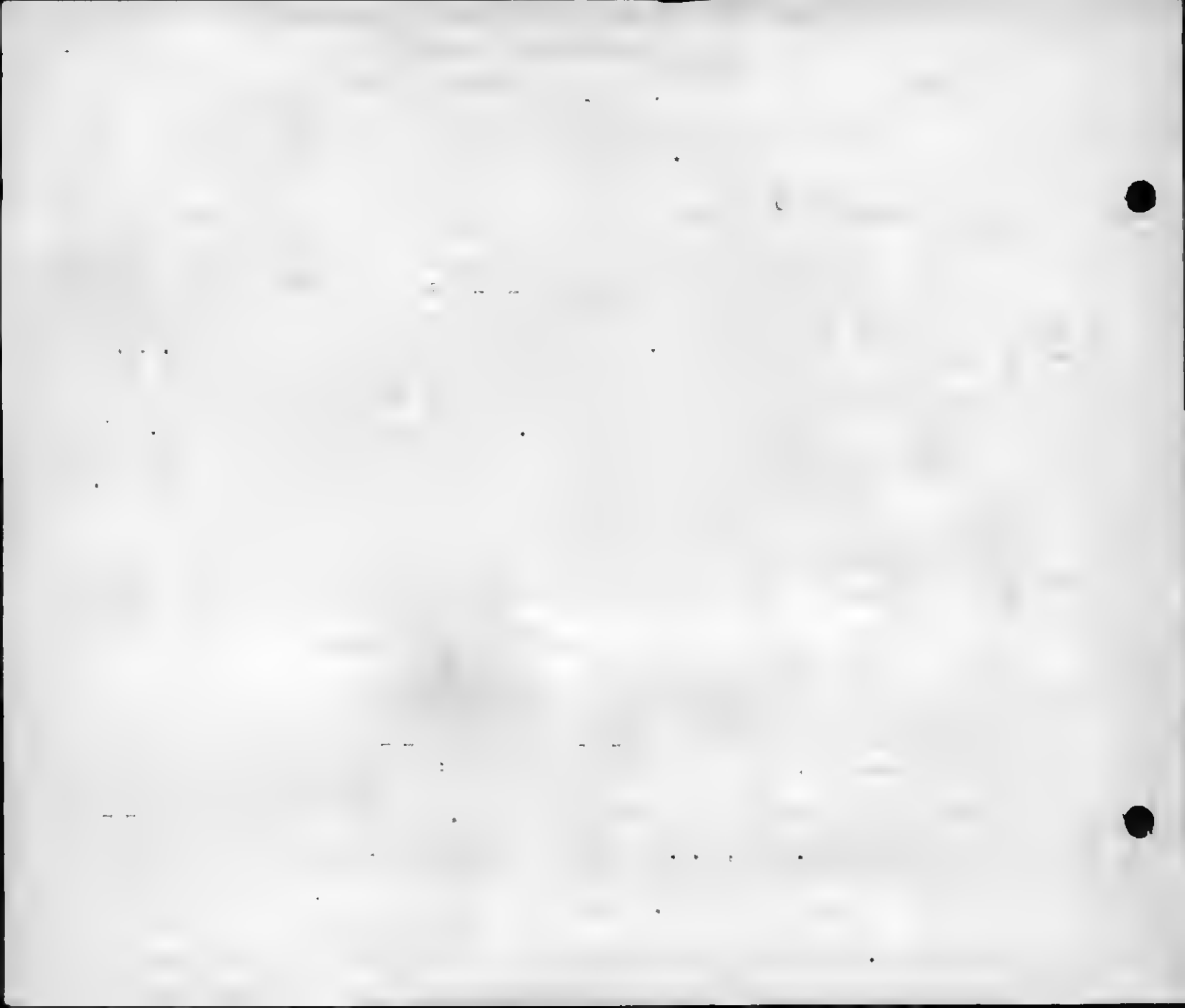
00151

0168

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE Maryland b. COUNTY Baltimore City ✓ | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Glen Burnie | | | | c. LENGTH OF STAY IN TB
8 days | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore 17, Maryland | | | | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Plaza Manor Nursing Home | | | |
| d. STREET ADDRESS
1410 McCulloh Street | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) SUSIE JOHNSON | | | | 4. DATE OF DEATH January 8, 1960 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
Negro | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
12-25-1886 | |
| 9. AGE (In years and day)
73 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Domestic worker | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Pvt. Family | | 11. BIRTHPLACE (State or foreign country)
Virginia | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | |
| 13. FATHER'S NAME
Nathan Henry | | | | 14. MOTHER'S MAIDEN NAME
Charlotte Roy | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
No | | | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT Address
Mrs. Earl Fitchette 2005 Bryant Ave. City 17 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Generalized arteriosclerosis
450.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile dementia
INTERVAL BETWEEN ONSET AND DEATH 1 yrs. | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from 12-30- 1959 , to 1-8- 1960 , that I last saw the deceased alive on January 2, 1960 , and that death occurred at 4:30A M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 400 N. Carrollton Avenue DATE SIGNED 1-8-1960 | | | | | | | |
| ACTUAL SIGNATURE James M. Pair M.D. 400 N. Carrollton Avenue 1-8-1960 | | | | | | | |
| PHYSICIAN'S NAME (Type) James M. Pair, M.D. Baltimore 23, Maryland | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
1/12/60 | | 22c. NAME OF CEMETERY OR CREMATORY
Mt. Auburn Cemetery | | 22d. LOCATION (City, town, or county) (State)
Baltimore Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Herbert E. Nutter -3810 Bonner Road | | | | 24a. REC'D BY REGISTRAR
DATE JAN 13 '60 | | 24b. REGISTRAR'S SIGNATURE
Arthur L. Knease | |

MEDICAL CERTIFICATION

TO HOSPITAL: ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

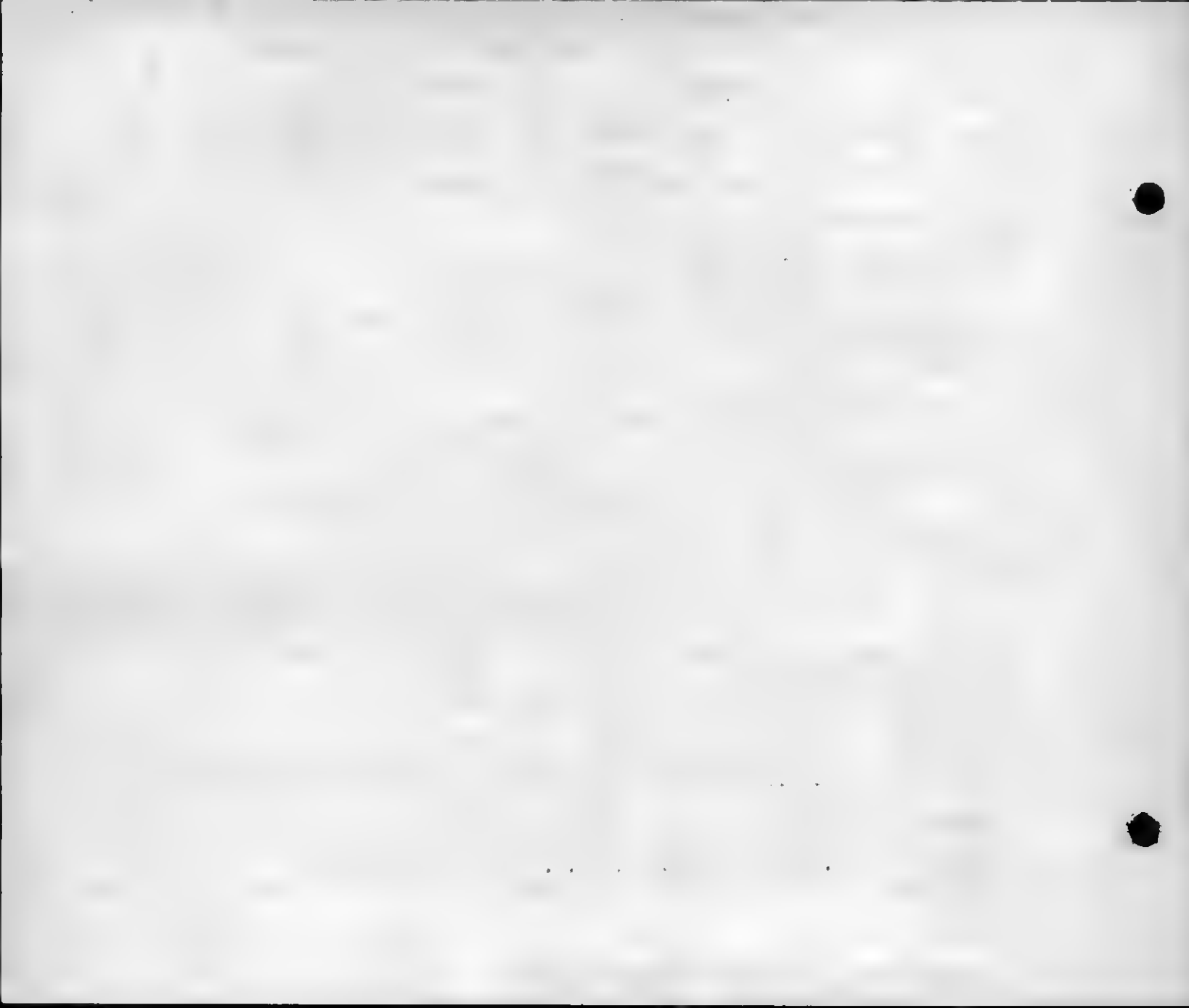
Reg. Dist. No.

00152

| | | | | | | | | | |
|--|--|--------------------------------------|--|---|--|--|--|--|----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Anne Arundel</u> 0169
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>
c. LENGTH OF STAY IN 1b <u>3 months</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>25 Stevens Rd. Glenwood</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Same</u> b. COUNTY <u>Same</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>
d. STREET ADDRESS <u>Same</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Mary E. Justice</u>
First Middle Last | | | | 4. DATE OF DEATH <u>January 5th.</u> 19 <u>60</u>
Month Day Year | | | | | |
| 5. SEX
<u>F</u> | | 6. COLOR OR RACE
<u>W.</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>5/3/27</u> | | 9. AGE (n years last birthday) <u>32</u> yrs.
IF UNDER 1 YEAR: Months <u> </u> Days <u> </u>
IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>DOMESTIC</u> | | 11. BIRTHPLACE (State or foreign country)
<u>New York, N.Y.</u> | | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>WALTER Gallagher</u> | | | | | 14. MOTHER'S MAIDEN NAME
<u>Unknown</u> | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>NONE</u> | | | 16. SOCIAL SECURITY NO.
<u>9</u> | | 17. INFORMANT <u>Frances McCormick (daughter) age 12.</u>
Address | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Laennec's cirrhosis with gastro-intestinal hemorrhage</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (b) <u> </u>
(c) stating the underlying cause last. DUE TO (c) <u> </u> | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <u> </u> <u>19</u> | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE
<u>W. Bradley King, Jr.</u> | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | |
| EXAMINER'S NAME (Type)
<u>W. Bradley King, Jr., M.D.</u> | | | | | DATE SIGNED
<u>1/6/60</u> | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | | 22b. DATE THEREOF
<u>1-11-60</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>GLEN HAVEN</u> | | | 22d. LOCATION (City, town, or county) (State)
<u>Anne Arundel City, Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>GEORGE SCHWAB FUNERAL HOME</u>
<u>2101 Frederick Ave.</u> | | | | | 24a. REC'D BY REGISTRAR
DATE <u>JAN 11 '60</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur J. Harris</u> | | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



CERTIFICATE OF DEATH

00153

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Anne Arundel</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)
o STATE <u>md</u> b. COUNTY <u>Anne Arundel</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Edgewater md</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Solley, A & Co.</u> | | | |
| c. LENGTH OF STAY IN TB
<u>7 yrs.</u> | | | | d. STREET ADDRESS
<u>Ann Arundel County Home</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Ann Arundel County Home</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>William</u> Middle <u>Ruben</u> Last <u>Ruben</u> | | | | 4. DATE OF DEATH
Month <u>January</u> Day <u>22</u> Year <u>1960</u> | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Aug. 4 1870</u> | |
| 9. AGE (In years last birthday)
<u>89</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | IF UNDER 24 HRS.
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Unknown</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>—</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Unknown</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | | | | | |
| 13. FATHER'S NAME
<u>Unknown</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO | | 17. INFORMANT Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u>
<u>42 d.</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cor. Ar. Insufficiency</u>
DUE TO (c) <u> </u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u> | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>October</u> 19 <u>52</u> , to <u>January 22</u> 19 <u>60</u> , that I last saw the deceased alive on <u>Jan 19</u> 19 <u>60</u> , and that death occurred at <u>3:00 P.</u> M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>31 Smithgate Ln</u> DATE SIGNED <u>1/23/60</u>
ACTUAL SIGNATURE <u>Maurice F. Klawans</u> M.D. <u> </u>
PHYSICIAN'S NAME (Type) <u>MAURICE F. KLAWANS</u> <u> </u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>1/23/60</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>County Home</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Edgewater Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Bernard O. Hardesty</u> | | | | ADDRESS
<u>Galwile Md.</u> | | 24a. REC'D BY REGISTRAR
DATE <u>JAN 28 '60</u> | |
| 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Krawns</u> | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0143 CERTIFICATE OF DEATH

00154

Reg. Dist. No.

| | | | |
|--|-----------------------------------|--|---|
| 1 PLACE OF DEATH
a. COUNTY <u>Anne Arundel</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>A. A.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dividing R.D.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Md.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Mary Rebecca Fork</u> | | 4 DATE OF DEATH <u>1-4</u> 19 <u>60</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8 DATE OF BIRTH <u>June 6, 1872</u> 87 yrs |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u> | | 12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>James Edward Rhodes</u> | | 14 MOTHER'S MAIDEN NAME <u>"Zink"</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> | | 16 SOCIAL SECURITY NO. <u>No</u> | |
| 17. INFORMANT <u>Daughter - Mrs. H. L. Myers</u> | | Address <u>#2</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u>
DUE TO
(c) _____ | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>1955</u> , 19____, to <u>1960</u> , 19____, that I last saw the deceased alive on <u>1-1-60</u> , 19____, and that death occurred at <u>11 P.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Robert R. Halpin</u> | | ADDRESS (Street, city or town, state) <u>Severna Park Md</u> DATE SIGNED <u>1-4-60</u> | |
| PHYSICIAN'S NAME (Type) <u>Robert R. Halpin</u> | | <u>2nd</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>1-2-1960</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u> | 22d. LOCATION (City, town, or county) (State) <u>BROOKLYN Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. G. ...</u> | | 24a. REC'D BY REGISTRAR <u>DATE JAN 7 '60</u> | |
| ADDRESS <u>Annapolis, Md.</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur E. ...</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. This certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



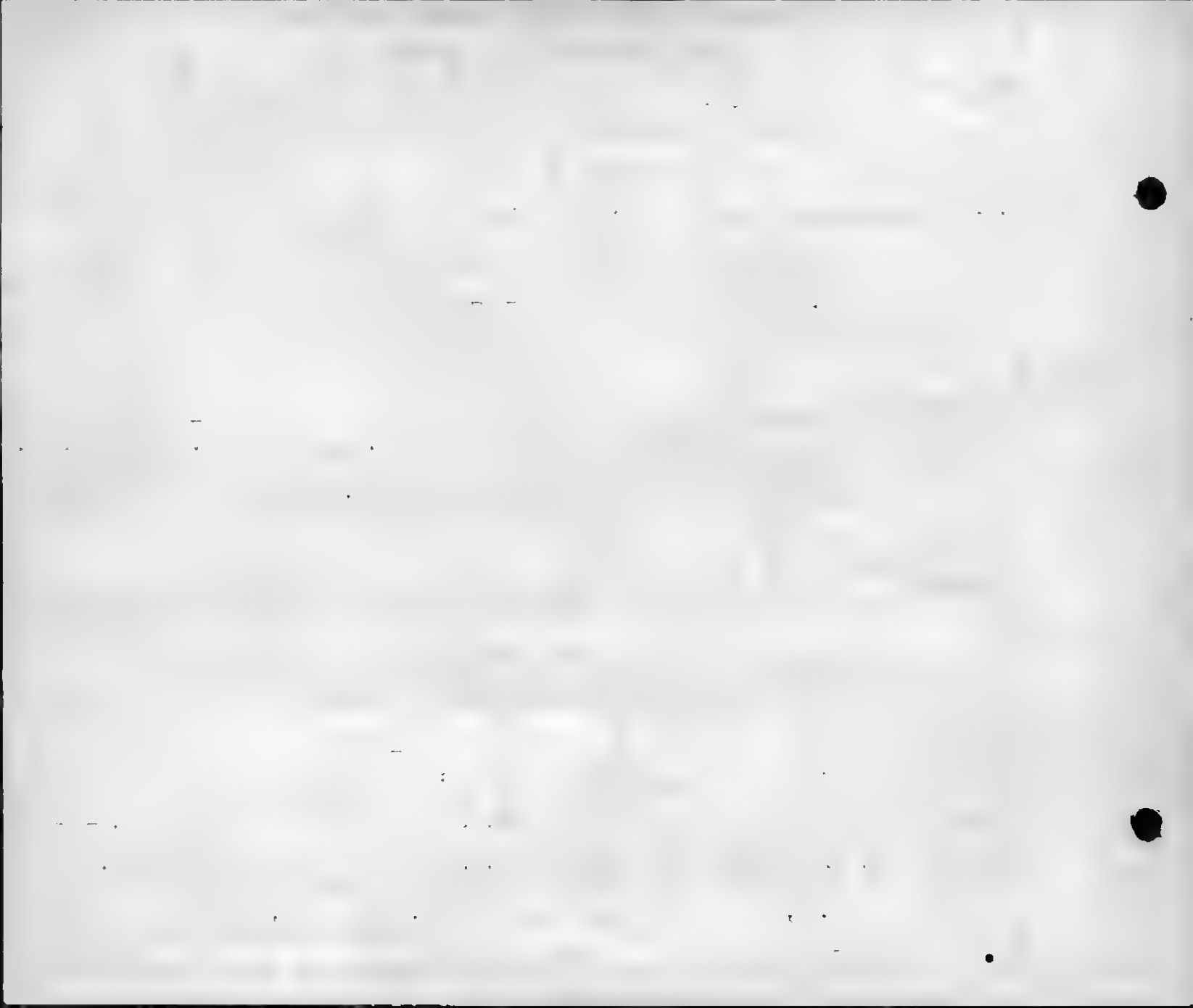
0129 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY ANNE ARUNDEL MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE MARYLAND b. COUNTY ANNE ARUNDEL | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
ANNAPOLIS | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
X ANNAPOLIS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
U.S. NAVAL HOSPITAL, ANNAPOLIS, MD. | | d. STREET ADDRESS
RT-1, EPPING FOREST ROAD | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First JULIA Middle CHARLOTTE Last LARSEN | | 4. DATE OF DEATH
Month 1 Day 28 Year 1960 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
CAUC. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
8-25-84 |
| 9. AGE (In years last birthday) yrs.
75 | | IF UNDER 1 YEAR
Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSE WIFE | | 10b. KIND OF BUSINESS OR INDUSTRY
JUNE HOME | |
| 11. BIRTHPLACE (State or foreign country)
WISCONSIN | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
PETER JENSEN | | 14. MOTHER'S MAIDEN NAME
(UNKNOWN) | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
B91 09 0719 | |
| 17. INFORMANT
(DAUGHTER) IRENE C. GRUNTOWICZ, RD., ANNAPOLIS, MD. | | Address RT-1, EPPING FOREST | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) INFLAMMATORY CELL CARCINOMA RT. BREAST
170x
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO
(c) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
4 months | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 14 January , 19 60 , to 1-28 , 19 60 , that I last saw the deceased alive on 28 January , 19 60 , and that death occurred at 2:10 P.M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
U.S. NAVAL HOSPITAL, ANNAPOLIS, MD. 1-29-60 | | | |
| ACTUAL SIGNATURE R.C. Laning | | M.D. U.S. NAVAL HOSPITAL, ANNAPOLIS, MD. | |
| PHYSICIAN'S NAME (Type) R. C. LANING LCDR MC USN | | U.S. NAVAL HOSPITAL, ANNAPOLIS, MD. | |
| 22a. BURIAL CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
Feb. 1, 1960 | 22c. NAME OF CEMETERY OR CREMATORY
Hillcrest Memorial Cem. | 22d. LOCATION (City, town, or county) (State)
Annapolis, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Hopping Funeral Home | | ADDRESS
Annapolis, Maryland | |
| 24a. REC'D BY REGISTRAR
FEB 2 '60 | | 24b. REGISTRAR'S SIGNATURE
Curtis J. Kraus | |

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



0130 CERTIFICATE OF DEATH

Reg. Dist. No.

00156

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Annapolis | | c. LENGTH OF STAY IN 1b
16 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Anne Arundel General Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) EDYTHE EATHE IRENE MACKENZIE | | 4. DATE OF DEATH
Month January Day 31 Year 1960 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
November 12, 1885 |
| 9. AGE (In years last birthday)
74 yrs | | 10. IF UNDER 1 YEAR
Months 74 Days 74 Hours 74 Min. 74 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
House wife | | 10b. KIND OF BUSINESS OR INDUSTRY
own home | |
| 11. BIRTHPLACE (State or foreign country)
Washington, D. C. | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
Unknown | | 14. MOTHER'S MAIDEN NAME
Unknown | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
no | | 16. SOCIAL SECURITY NO.
577 07 3982 | |
| 17. INFORMANT
Hospital Record Office | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Car of kidney angiosarcoma type
180x DUE TO
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last
(b) with Metastases to bones DUE TO
(c) multiple pathologic fractures
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
hypertensive CVD
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from January 15, 1960 , to 1-31, 1960 , that I last saw the deceased alive on 1-30, 1960 , and that death occurred at 8:15 A.M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 45 Franklin St., Annapolis, Md. DATE SIGNED 2/1/60 | | | |
| ACTUAL SIGNATURE Edith Rodler | | M.D. Edith Rodler | |
| PHYSICIAN'S NAME (Type) Edith Rodler | | Annapolis, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
Feb. 3, 1960 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Congressional Cemetery | | 22d. LOCATION (City, town, or county) (State)
Washington, D.C. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Hopping Funeral Home | | ADDRESS
Annapolis, Md. | |
| 24a. REC'D BY REGISTRAR
FEB 3 '60 | | 24b. REGISTRAR'S SIGNATURE
Curtis L. Howard | |

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the hospital prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | |
|---|--|--|--|--|--|-------------------------------------|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| Reg. Dist. No. 0157 | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>AA CO.</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>New Jersey</u> b. COUNTY <u>Mercer</u> | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Annapolis</u> | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Trenton</u> | | | d. STREET ADDRESS
<u>Rt. 1 - Babers Bassett</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>10 A. HANE. HENCKEL GEN.</u> | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>MARY</u> Middle <u>MAZUR</u> Last <u>MAZUR</u> | | | | | 4. DATE OF DEATH
Month <u>1</u> Day <u>18</u> Year <u>1960</u> | | | | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>1-3-1912</u> | | 9. AGE (In years last birthday) <u>48</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Own Home</u> | | 11. BIRTHPLACE (State or foreign country)
<u>POLAND</u> | | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | |
| 13. FATHER'S NAME
<u>Anthony Wister</u> | | | | | 14. MOTHER'S MAIDEN NAME
<u>JULIA SZWORSKA</u> | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>(If yes, give war or dates of service)</u> | | 17. INFORMANT
<u>Hospital Record</u> | | | Address | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Fracture Skull</u>
<u>816 X</u> DUE TO <u>Why look injury neck</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Why look injury neck</u>
DUE TO (c) <u>Why look injury neck</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Why look injury neck</u>
INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>Auto accident - auto struck trailer tractor</u> | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. <u>1-18 1960</u> | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>Highway</u> | | 20f. (City or town)
<u>A.A. MD</u> | | (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE <u>E. Linhardt</u> | | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | |
| EXAMINER'S NAME (Type) <u>E. Linhardt</u> | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | |
| | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF
<u>1-20-1960</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>ST. HEDWIG'S CEM</u> | | | 22d. LOCATION (City, town, or county) (State)
<u>EWING TOWNSHIP NJ.</u> | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>JOHN M. TAYLOR</u> | | | | | ADDRESS
<u>SOU ANNAPOLIS MD</u> | | 24a. REC'D BY REGISTRAR
<u>DATE JAN 20 '60</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Knaus</u> |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 27

00158

0171

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Anne Arundel</u> <input checked="" type="checkbox"/> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Fort George G. Meade</u> | | | | c. LENGTH OF STAY IN 1b
<u>3 days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>U. S. Army Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>FOSTER</u> Middle <u>K.</u> Last <u>McLEROY JR</u> | | | | 4. DATE OF DEATH
Month <u>January</u> Day <u>27</u> Year <u>19 60</u> | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>Cau</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>28 September 59</u> | |
| 9. AGE (In years last birthday)
<u>4</u> yrs. | | IF UNDER 1 YEAR
Months <u>4</u> Days <u></u> Hours <u></u> Min. <u></u> | | IF UNDER 24 HRS
Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>None</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>None</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Anchorage, Alaska</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | | | | | | |
| 13. FATHER'S NAME
<u>Foster K. McLeroy</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Sandra J. Humphries</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
<u>no</u> | | | | 16. SOCIAL SECURITY NO
<u>NONE</u> | | 17. INFORMANT
<u>Father</u> Address <u>Pasadena, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Heart Failure</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Respiratory Infection</u>
DUE TO
(c) <u>Congenital Heart Disease</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>3 hours</u>
<u>3 days</u>
<u>Since Birth</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Hour <u></u> a. m. <u>19</u> p. m. <u></u>
Month, Day, Year | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from <u>27 January, 19 60</u> , to <u>27 January, 19 60</u> , that I last saw the deceased alive on <u>27 January, 19 60</u> , and that death occurred at <u>8:25 PM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Norman B. Sher</u> M.D. | | | | ADDRESS (Street, city or town, state) <u></u> DATE SIGNED <u>27 Jan 60</u> | | | |
| PHYSICIAN'S NAME (Type) <u>NORMAN B. SHER, CAPT., MC</u> | | | | U.S. Army Hospital, Fort Geo G. Meade, Md | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>29 Jan. 60</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Glen Haven Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Glen Burnie, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>R. V. Singleton</u> ADDRESS <u>Glen Burnie, Md</u> | | | | 24a. REC'D BY REGISTRAR
DATE <u>FEB 2 '60</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Hines</u> | |

0000000000



Item 18 File 255 2-6-60 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

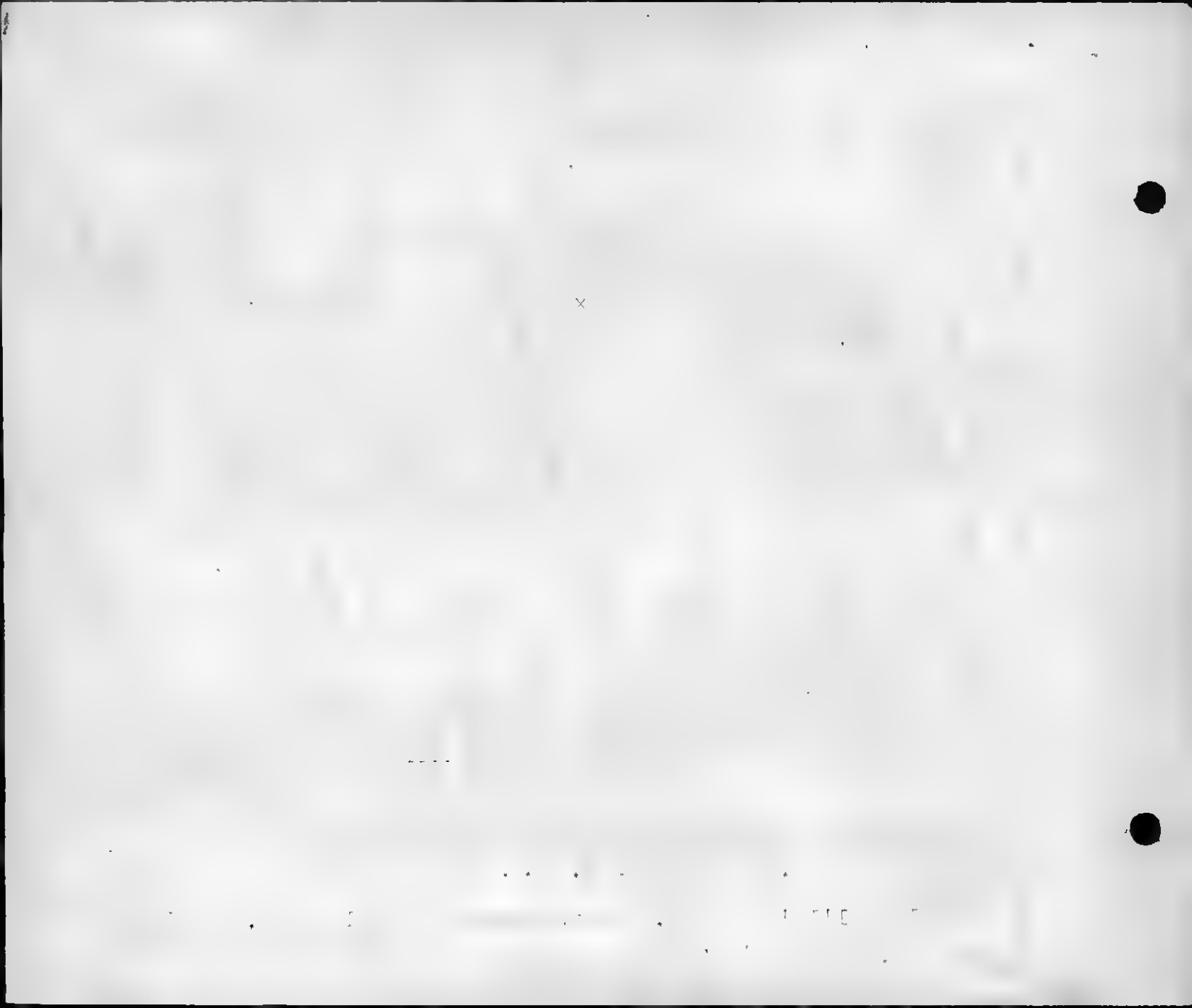
00159

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Anne Arundel County</u> 0172 <u>MARYLAND</u> | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Jessup</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>?</u> <u>18 X-20</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Maryland House of Correction</u> | | d. STREET ADDRESS
<u>?</u> | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
<u>John Henry Milburn</u> | | 4. DATE OF DEATH
Month Day Year
<u>January 12 1960</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
<u>11/8/20</u> |
| 9. AGE (In years last birthday)
<u>39 yrs.</u> | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Mechanic</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
<u>St. Mary's County, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>John Milburn</u> | | 14. MOTHER'S MAIDEN NAME
<u>Anna Mae Russell</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) <u>Merchant Marines</u> | | 16. SOCIAL SECURITY NO.
<u>216-07-9243</u> | |
| 17. INFORMANT
<u>Md. House of Correction Records, Jessup, Md.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Viral pneumonitis, acute, severe</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>472X</u>
DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
<u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE
<u>W. Bradley King, Jr.</u> | | DATE SIGNED
<u>1/13/60</u> | |
| EXAMINER'S NAME (Type)
<u>W. Bradley King, Jr., M.D.</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 22b. DATE THEREOF
<u>1/14/60</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>St. Peters Cemetery</u> | 22d. LOCATION (City, town, or county) (State)
<u>Baltimore, Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Howard H. Hubbard</u> | | 24a. REC'D BY REGISTRAR
<u>JAN 15 '60</u> | |
| ADDRESS
<u>4107 Wilkens Avenue</u> | | 24b. REGISTRAR'S SIGNATURE
<u>C. L. Kline</u> | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

00160

0173

CERTIFICATE OF DEATH

Item 12 Filed 2-25-60

| | | | |
|---|--------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Anne Arundel Co., MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
2601-4 | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Glen Burnie | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Plaza Manor | | d. STREET ADDRESS
1706 Westwood Avenue
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First
Huey
Middle
A. Molok
Last | | 4. DATE OF DEATH
Month
January
Day
23
Year
1960 | |
| 5. SEX
Male | 6. COLOR OR RACE
Col | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
December 28, 1889
9. AGE (In years last birthday) yrs
70 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Butler | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country)
Ontario Canada |
| 13. FATHER'S NAME
Francis Molok | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 14. MOTHER'S MAIDEN NAME
Mary Howard | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service) <input type="checkbox"/> | |
| 16. SOCIAL SECURITY NO.
215-22-2705 | | 17. INFORMANT
Marjorie Ockimey
Address
1706 Westwood Ave | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic and hypertensive cardiovascular disease.
443X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH
over 10 yrs. | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from December 11 1959 to January 23, 1960 , that (I) (we) last saw the deceased alive on January 16, 1960 and that death occurred at 4:45 PM , from the causes and on the date stated above | | | |
| 22a. SIGNATURE
James M. Pair | | 22b. DATE
January 25, 1960 | |
| 22c. PHYSICIAN'S NAME (Type)
James M. Pair, M.D. | | 22d. ADDRESS
400 N. Carrollton Ave. Balto. 23, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
1-27-1960 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Arbutus Memorial | | 23d. LOCATION (City, town, or county) (State)
Arbutus, Maryland | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
Arlington S. Phillips | | 25a. REC'D BY REGISTRAR
JAN 27 '60 | |
| ADDRESS
1808 N. Monroe St. | | 25b. REGISTRAR'S SIGNATURE
James S. Thomas | |



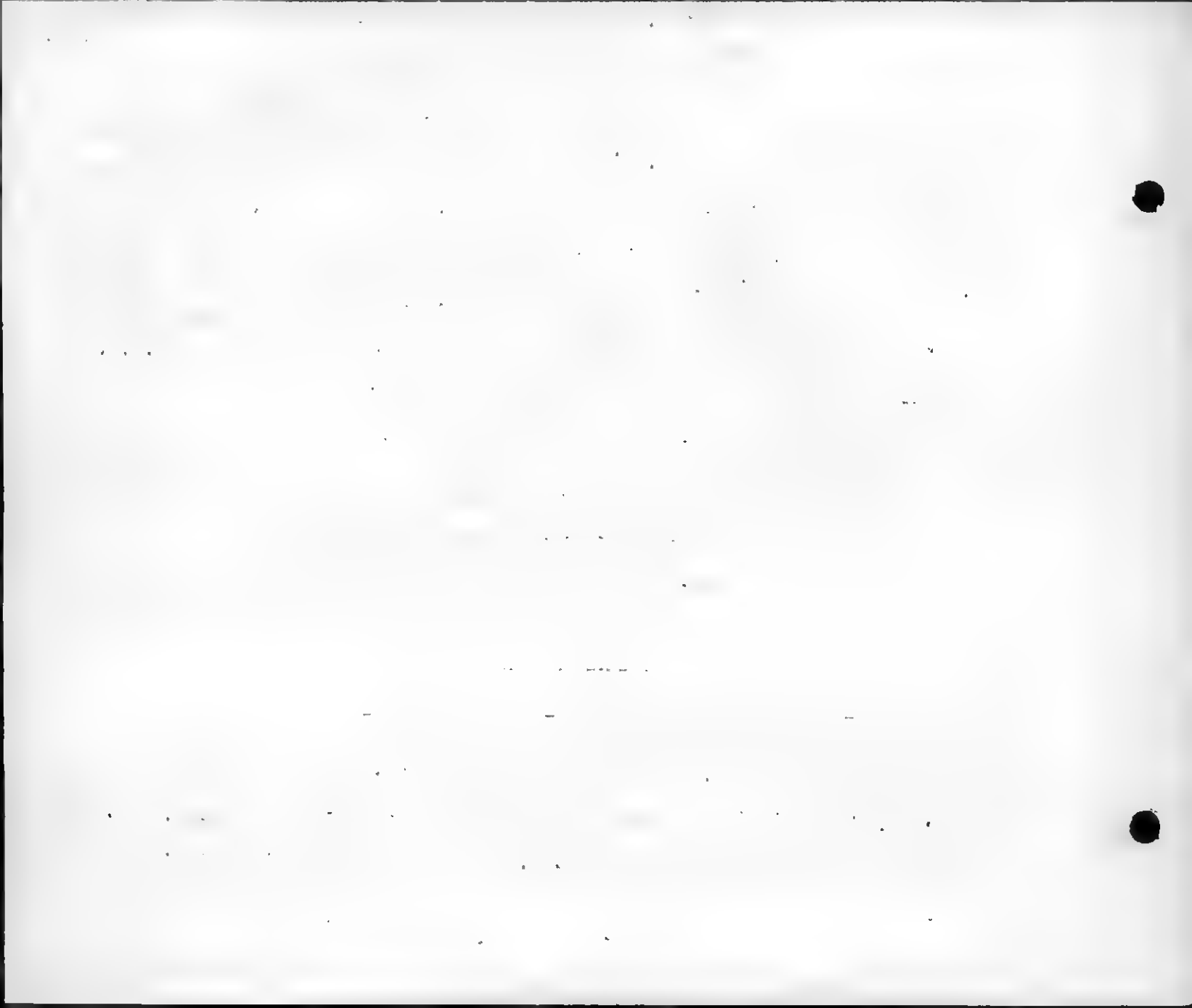
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00161

0174 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|--|--|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY
Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Crownsville
c. LENGTH OF STAY IN 1b
8mo. 10 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Crownsville State Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore
d. STREET ADDRESS
737 W. Franklin Street
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Robert Henry Monroe | | | | 4. DATE OF DEATH
Month Day Year
1 12 19 60 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
Negro | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
June 13, 1889 | |
| 9. AGE (In years last birthday)
70 yrs | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Laborer | | | | 10b. KIND OF BUSINESS OR INDUSTRY
----- | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
Frank Monroe | | | | 14. MOTHER'S MAIDEN NAME
Mary Shields | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO
213-09-7178 | | INFORMANT
Hospital Records | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart Failure
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic Cardiovascular Disease
DUE TO
(c) Generalized Arteriosclerosis, Severe | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDIT ON GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
----- | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m.
----- 19 | | 20d. INJURY OCCURRED
While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
----- | | 20f. (City or town) (County) (State)
----- | |
| 21. I certify that I attended the deceased from 5/2 , 19 58 , to 1/12 , 19 60 , that I last saw the deceased alive on 1/12 , 19 60 , and that death occurred at 1:30P. M., from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
<i>Hildegard Heard Reissman</i> | | M.D.
Crownsville State Hospital, Md. | | DATE SIGNED
1/13/60 | | | |
| PHYSICIAN'S NAME (Type)
Hildegard Heard Reissman, M. D. | | Crownsville State Hospital, Md. | | 1/13/60 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
1/14/60 | | 22b. DATE THEREOF
1/14/60 | | 22c. NAME OF CEMETERY OR CREMATORY
Baltimore | | 22d. LOCATION (City, town, or county) (State)
Baltimore Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<i>Charles E. Rice</i> | | ADDRESS
661 W. Baltimore | | 24a. REC'D BY REGISTRAR
JAN 15 '60 | | 24b. REGISTRAR'S SIGNATURE
<i>James S. Thoma</i> | |



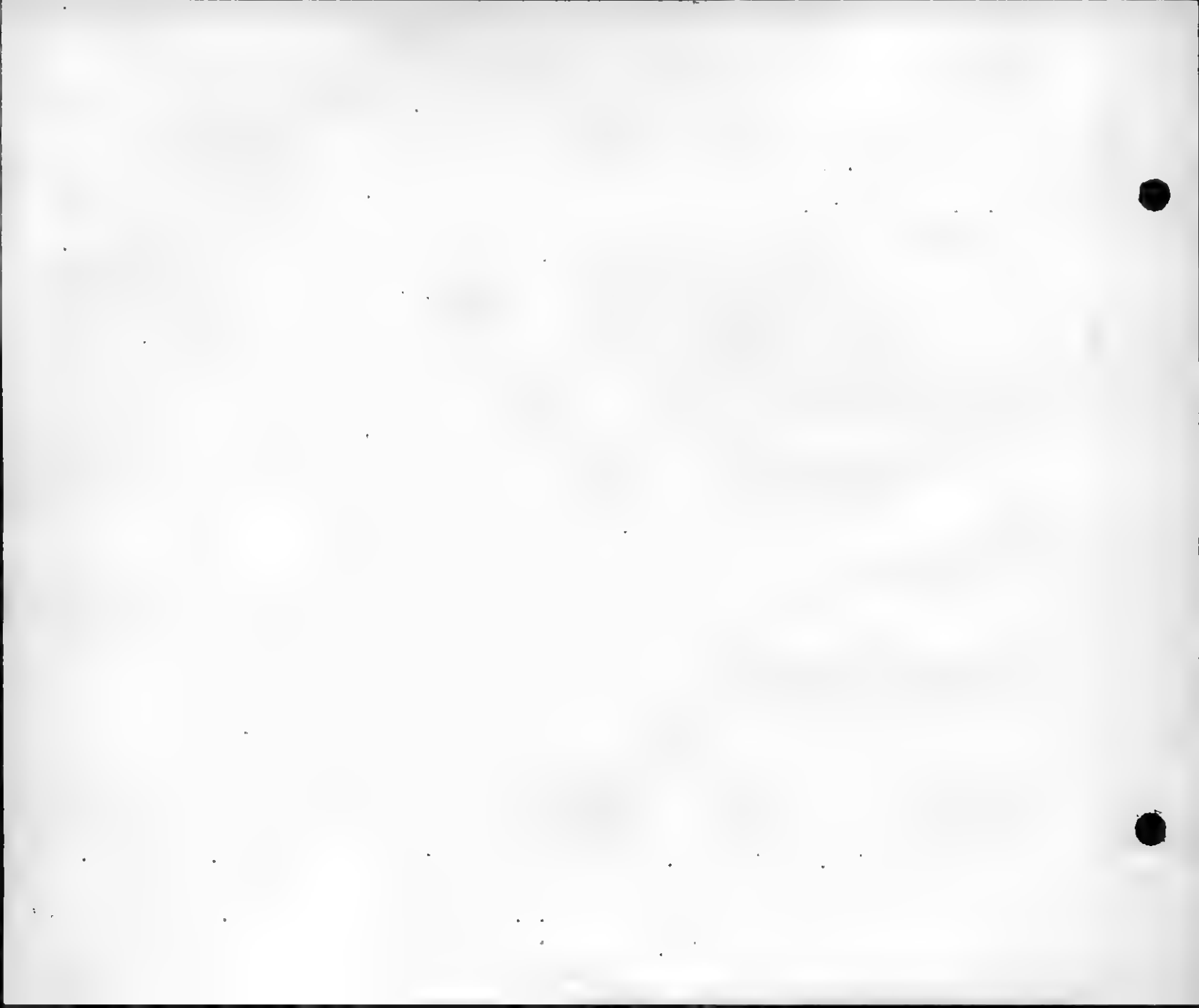
0175 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort George G. Meade | | c. LENGTH OF STAY IN lb
1 Day | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
U. S. Army Hospital | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Severn | |
| | | f. STREET ADDRESS
Brodsky's Trailer Park | |
| 3. NAME OF DECEASED (Type or print)
First Not Named Middle Moore Last Moore | | 4. DATE OF DEATH
Month January Day 10 Year 1960 | |
| 5. SEX
Female | 6. COLOR OR RACE
Cau | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
9 January '60 |
| 9. AGE (In years lost birthday) yrs.
1 | | 10. IF UNDER 1 YEAR
Months 1 Days 2 Hours 2 Min. | |
| 10a. USJA. OCCUPATION (Give kind of work done during most of working life, even if retired)
- | | 10b. KIND OF BUSINESS OR INDUSTRY
- | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Kenneth James Moore | | 14. MOTHER'S MAIDEN NAME
Karen Madara | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
- | | 16. SOCIAL SECURITY NO.
- | |
| 17. ADDRESS
Mother - Brodsky's Trailer Park, Severn, Md | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Atelectasis
762.5 DUE TO
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Prematurity
DUE TO (c) - | | INTERVAL BETWEEN ONSET AND DEATH
26 hours | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) - | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 9 January 1960 to 10 January 1960 , that I last saw the deceased alive on 10 January 1960 , and that death occurred at 2:30 PM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Roger C. Moyer</i> M.D. | | ADDRESS (Street, city or town, state) DATE SIGNED | |
| PHYSICIAN'S NAME (Type) ROGER C. MOYER, CAPT, MC, US Army Hospital, Fort George G. Meade, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | 22b. DATE THEREOF
11 Jan 1960 | 22c. NAME OF CEMETERY OR CREMATORY
Laboratory, U.S. Army Hospital, Ft Geo G. Meade, Maryland | 22d. LOCATION (City, town, or county) (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE BETTY M. ADAMS, Capt., MSC | | 24a. REC'D BY REGISTRAR
USAH, Fort Geo G Meade, Md | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kinn |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



0176 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>A.A. Co.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MILLERSVILLE</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>EDGEWATER</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SANN'S NURSING HOME</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>ROBERT T. MOORE</u> | | 4. DATE OF DEATH <u>Jan 11 - 1960</u> | |
| 5. SEX <u>M - White</u> | 6. COLOR OR RACE <u>White</u> | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 8. DATE OF BIRTH <u>SEPT. 2 - 1878</u> |
| WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. AGE (In years lost birthday) <u>81</u> yrs | IF UNDER 1 YEAR Months Days Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done, drying most of working life, even if retired) <u>FARMER</u> | 10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u> | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> |
| 13. FATHER'S NAME <u>SILAS H. MOORE</u> | | 14. MOTHER'S MAIDEN NAME <u>SOPHIA DAVIS</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>MARY NEWBERGER, MILLERSVILLE</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Lobar Pneumonia</u>
DUE TO <u>General debility</u>
(b) <u>Paralysis - Residual</u>
DUE TO <u>Senility - Parkinsonian Syndrome</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH
<u>10 days</u>
<u>3 years</u>
<u>1 year</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. b. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Dec 4, 1959</u> to <u>Jan 11 - 60</u> , that I last saw the deceased alive on <u>Jan 11 - 60</u> , and that death occurred at <u>12:30 PM</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>JOSEPH LIPSKEY</u> M.D. | | ADDRESS (State, city or town, State) <u>Edgewater Md</u> DATE SIGNED <u>1/11/60</u> | |
| PHYSICIAN'S NAME (Type) <u>JOSEPH LIPSKEY</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF <u>1-16-60</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>WOODLAND CEM.</u> | 22d. LOCATION (City, town, or county) <u>N. S. BELL PORT LONG ISL.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN M. TAYLOR SON ANNAPOLIS MD.</u> | | 24a. REC'D BY REGISTRAR <u>JAN 14 '60</u> | |
| ADDRESS | | 24b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u> | |



CERTIFICATE OF DEATH

Reg. Dist. No.

00164

0177

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY <i>aa</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE <i>MD</i> b. COUNTY <i>aa</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Jewell Rd</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Jewell</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <i>Kate Belle Maryland</i> | | 4. DATE OF DEATH Month <i>7</i> Day <i>7</i> Year <i>1960</i> | |
| 5. SEX <i>F</i> | 6. COLOR OR RACE <i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Sept 6, 1863</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Home</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) <i>96</i> yrs |
| 11. BIRTHPLACE (State or foreign country) <i>MD LOWER MARYLAND</i> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <i>Wm Henry Madrymple</i> | | 14. MOTHER'S MAIDEN NAME <i>Elyse Ward</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <i>Cora Myers</i> Address <i>Jewell, Md.</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cardiac failure</i>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <i>19</i> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <i>Jan 2</i> , 19 <i>60</i> , to <i>Jan 7</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>11/7</i> , 19 <i>60</i> , and that death occurred at <i>5:30 P</i> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>H W Ward</i> M.D. | | DATE SIGNED <i>11/7/60</i> | |
| PHYSICIAN'S NAME (Type) <i>Owens MD</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i> | 22b. DATE THEREOF <i>Jan 10/60</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>FRIENDSHIP</i> | 22d. LOCATION (City, town, or county) (State) <i>MD</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Bernard Hardisty - Beltsville Md</i> | | 24a. REC'D BY REGISTRAR <i>JAN 12 '60</i> | 24b. REGISTRAR'S SIGNATURE <i>Wm L. Thoma</i> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



00166

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

| | | | |
|--|----------------------------------|---|---------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <i>Anne Arundale</i> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <i>Maryland</i>
b. COUNTY <i>Baltimore</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Crownsville</i> | | c. LENGTH OF STAY IN 1b
<i>5 years</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<i>Crownsville State Hospital</i> | | d. STREET ADDRESS <i>1105 Highland Rd. Baptist Home 1940-1944 3201 Bayridge Way</i> | |
| 3. NAME OF DECEASED
(Type or print)
<i>Sallie Morton</i> | | 4. DATE OF DEATH
Month <i>January</i> Day <i>10</i> Year <i>1960</i> | |
| 5. SEX
<i>Female</i> | 6. COLOR OR RACE
<i>negro</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>1884</i> |
| 9. AGE (In years last birthday)
<i>75</i> yrs. | | IF UNDER 1 YEAR
Months <i>4</i> Days <i>5</i> Hours <i>41</i> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY
<i>?</i> | |
| 11. BIRTHPLACE (State or foreign country)
<i>VA</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | |
| 13. FATHER'S NAME
<i>Harmon</i> | | 14. MOTHER'S MAIDEN NAME
<i>Unknown</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<i>NO</i> | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
<i>Medical records</i> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>450.0</i> DUE TO <i>Circulatory insufficiency</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>generalized arteriosclerosis</i>
(c) <i>aging</i> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>1 - advanced cerebral arteriosclerosis 2 - Blind</i> | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH
<i>5 days</i> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. <i>19</i> p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>January 8, 1960</i> to <i>January 10, 1960</i> ...that I last saw the deceased alive on <i>January 10, 1960</i> ...and that death occurred at <i>6:15 AM</i> , from the causes and on the date stated above.
ADDRESS (street, city or town, state) <i>Crownsville State Hospital</i> DATE SIGNED <i>Jan 12 '60</i> | | | |
| ACTUAL SIGNATURE <i>James M. Hays, M.D.</i> | | M.D. <i>Crownsville Md</i> | |
| PHYSICIAN'S NAME (Type) <i>Lester M. Hays, M.D.</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF <i>1/14/60</i> | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>St. Mary's</i> | | 22d. LOCATION (City, town, or county) (State) <i>Crownsville - Md</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Maxwell R. Hays, 1380 Queen St. N</i> | | ADDRESS | |
| 24a. REC'D BY REGISTRAR
DATE <i>JAN 12 '60</i> | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hays</i> | |



0179 CERTIFICATE OF DEATH

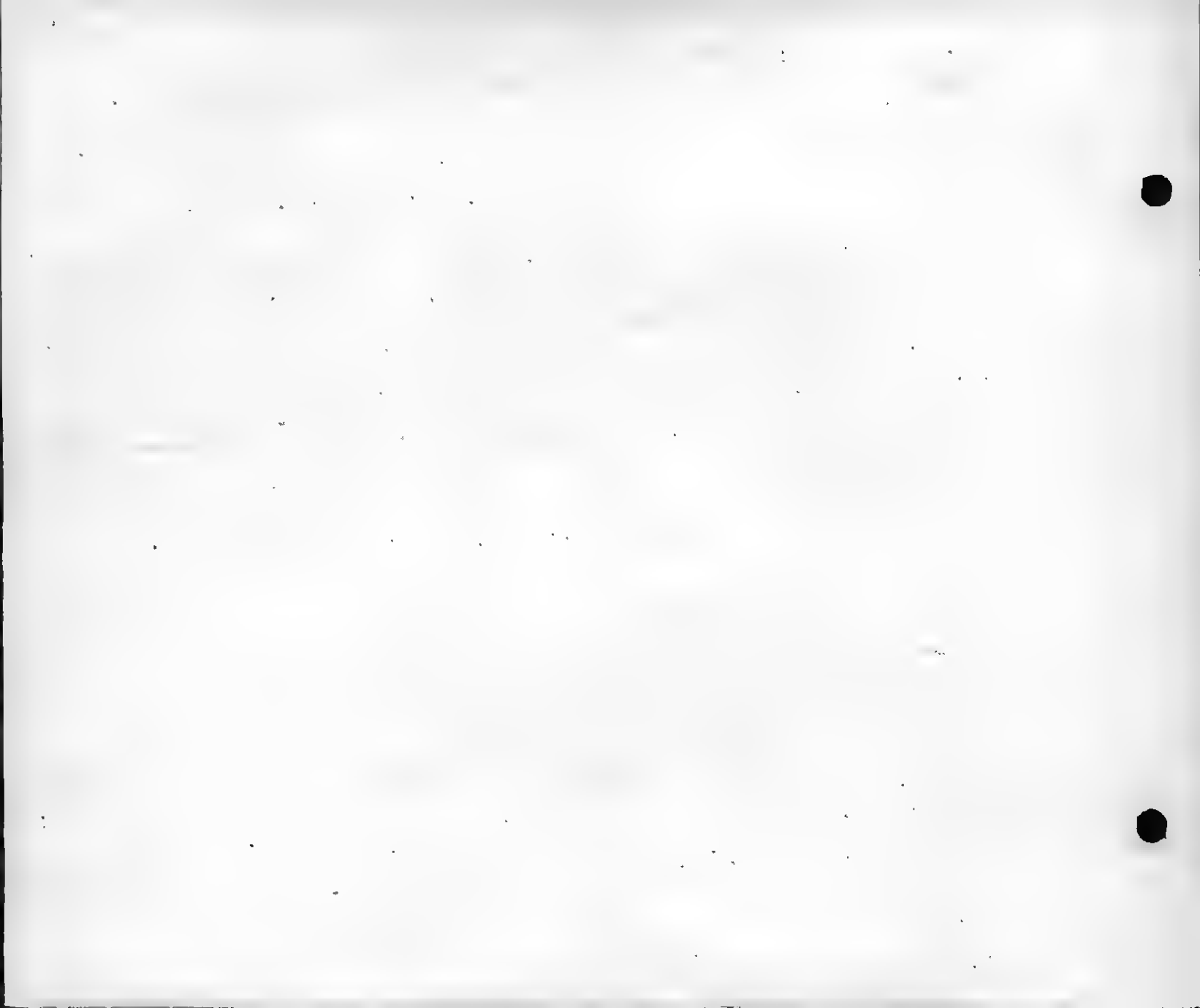
Reg. Dist. No.

00167

| | | | |
|--|------------------------------------|--|---|
| 1. PLACE OF DEATH
o COUNTY <i>Arundel</i> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE <i>MD.</i> b. COUNTY <i>Arundel</i> | |
| b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Kurac</i> | | c. LENGTH OF STAY IN 1b <i>45 Days</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <i>THEOPHANO</i> First Middle Last <i>MOUSHABEK</i> | | 4. DATE OF DEATH Month <i>Jan.</i> Day <i>11</i> Year <i>1960</i> | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>1891</i> |
| 9. AGE (In years last birthday) <i>68 yrs.</i> | | 10. IF UNDER 1 YEAR Months Days Hours Min. | 11. IF UNDER 24 HRS |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) <i>Jerusalem</i> |
| 12. CITIZEN OF WHAT COUNTRY? <i>Jerusalem</i> | | 13. FATHER'S NAME <i>FOTE THEODORE</i> | |
| 14. MOTHER'S MAIDEN NAME <i>THEODORI</i> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> | |
| 16. SOCIAL SECURITY NO. <i>no</i> | | INFORMANT <i>Eleanor J. Moushabek</i> Address <i>2101 S. Ritchie Highway</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>420.0 Coronary thrombosis</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic heart disease</i>
(c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>Nov. 30, 1959</i> to <i>Jan. 11, 1960</i> that I last saw the deceased alive on <i>Jan. 11, 1960</i> , and that death occurred at <i>10:00</i> M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Edmond J. Moushabek</i> M.D. | | ADDRESS (Street, city or town, state) <i>2101 S. Ritchie Highway</i> DATE SIGNED <i>Jan. 11, 60</i> | |
| PHYSICIAN'S NAME (Type) <i>EDMOND I. MOUSHABEK</i> | | <i>Glen Burnie Maryland</i> | |
| 22a. BURIAL, CREMAT. OR REMOVAL (Specify) | 22b. DATE THEREOF <i>Jan 12-60</i> | 22c. NAME OF CEMETERY OR CREMATORY <i>Glen Burnie Cemetery</i> | 22d. LOCATION (City, town, or county) (State) <i>Arundel Maryland</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Edmond J. Moushabek</i> | | ADDRESS <i>Glen Burnie Md</i> | 24a. REC'D BY REGISTRAR DATE <i>JAN 15 '60</i> |
| | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i> | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00163

Reg. Dist. No.

| | | | | | | | | | | | | | |
|--|--|----------------------------------|---------------------------------|---|--|--|--|---|---|--|--|-----------------|--|
| 1. PLACE OF DEATH
a. COUNTY ANNE ARUNDEL 0132
MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY ANNE ARUNDEL | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
ANNAPOLIS | | | c. LENGTH OF STAY IN 1b

 | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
ANNAPOLIS | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

 | | | | | | e. STREET ADDRESS
Quarters D, Nav. Exp. Sta. | | f. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Robert Lutes MOYER | | | | 4. DATE OF DEATH
Month Day Year
1 18 19 60 | | | | | | | | | |
| 5. SEX
M | | 6. COLOR OR RACE
Cauc. | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
12 June 1919 | | 9. AGE (In years, months, and days)
40 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
U.S. NAVY | | | | 10b. KIND OF BUSINESS OR INDUSTRY
ARMED FORCES | | 11. BIRTHPLACE (State or foreign country)
Montana | | | 12. CITIZEN OF WHAT COUNTRY?
USA | | | | |
| 13. FATHER'S NAME
Willard W. Moyer | | | | | | 14. MOTHER'S MAIDEN NAME
Ethel Lutes | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes | | | | 16. SOCIAL SECURITY NO. (If yes, give year or dates of service)
WW II ***** | | 17. INFORMANT
Address Qtrs. D, U.S.
Wife: Gene E. Moyer NAVAL EXP. STATION | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Thrombosis, Circumflex Coronary Artery
DUE TO
(c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
1 hour | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | |
| Pulmonary edema and congestion | | | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

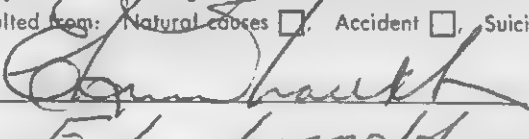
 | | | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.

 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

 | | 20f. (City or town)

 | | (County)

 | | (State)

 | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
 | | | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | DATE SIGNED
18 January 1960 | | | | |
| EXAMINER'S NAME (Type)
E. L. Lutes | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 22b. DATE THEREOF
1-20-60 | | 22c. NAME OF CEMETERY OR CREMATORY
U.S. Naval Academy Cemetery, | | | 22d. LOCATION (City, town, or county) (State)
Annapolis, Maryland | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Wm. C. Ok, Inc., 1217 St. Paul Street | | | | | | ADDRESS

 | | | 24a. REC'D BY REGISTRAR
JAN 20 1960 | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Frank | | |

MEDICAL CERTIFICATION

1. DEATH CERTIFICATE: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 2. FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



0180

CERTIFICATE OF DEATH

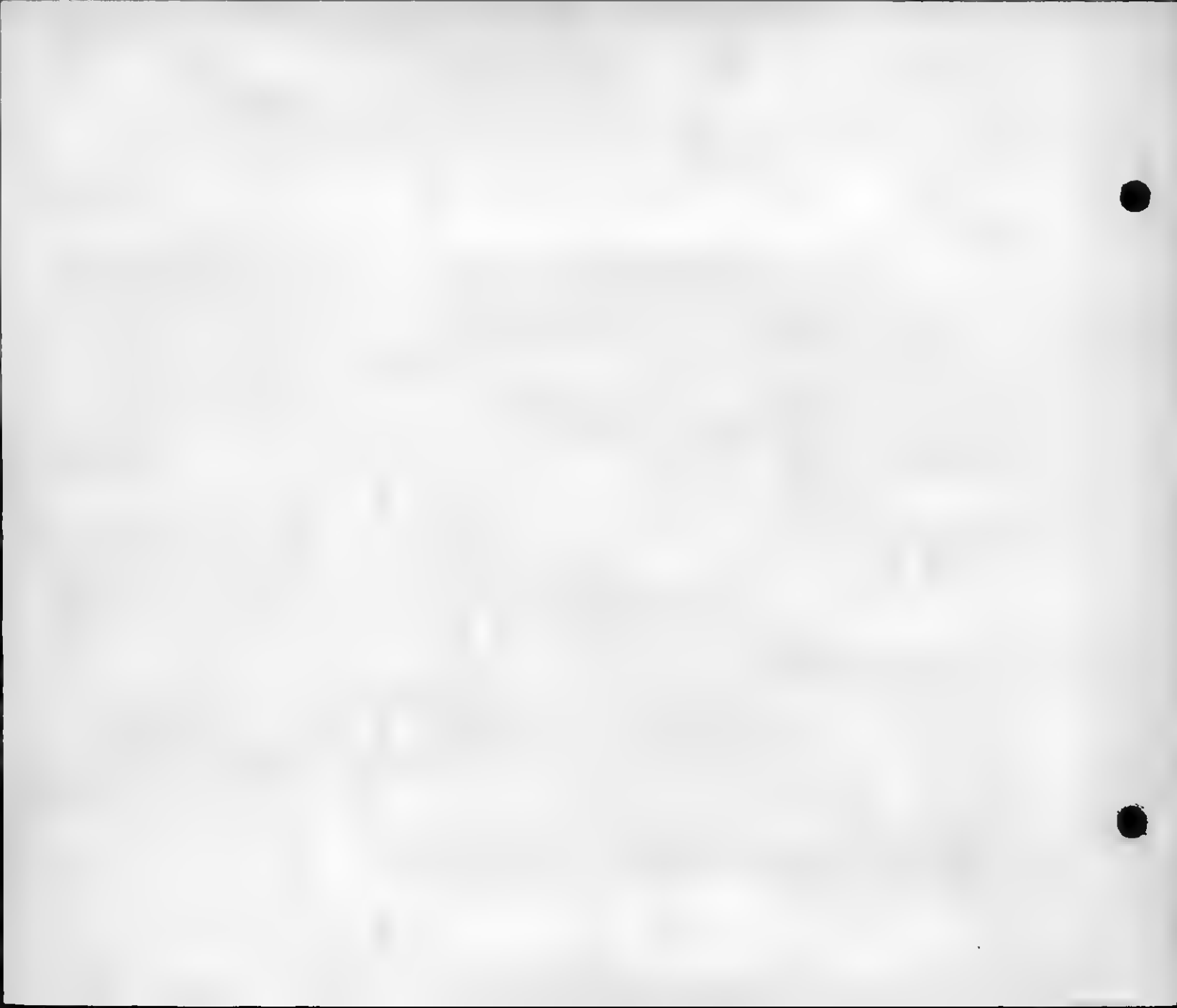
00169

Reg. Dist. No.

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>1</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>S. N. T. BERTH</u> | | | | c. LENGTH OF STAY IN TB
<u>3 WEEKS</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>8 CRANFORD ROAD</u> | | | | e. STREET ADDRESS
<u>325 SOUTHWOOD AVE</u> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last
<u>AMANDA (MAMIE) A MCVICKIN</u> | | | | 4. DATE OF DEATH Month Day Year
<u>JAN 13 1960</u> | | | |
| 5. SEX
<u>FEMALE</u> | | 6. COLOR OR RACE
<u>WHITE</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>SEPT. 30, 1883</u> | |
| 9. AGE (In years last birthday)
<u>76</u> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>RESTAURANT</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>RESTAURANT</u> | | | |
| 11. BIRTHPLACE (State or foreign country)
<u>YUGO-SLAVIA</u> | | | | 12. CITIZEN OF WHAT COUNTRY?
<u>YUGO-SLAVIA</u> | | | |
| 13. FATHER'S NAME
<u>ALABER</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>BEATRICE MCVICKIN</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
<u>NO</u> | | | | 16. SOCIAL SECURITY NO.
<u>2-3-22-761</u> | | | |
| 17. INFORMANT
<u>BENNETT MCVICKIN</u> | | | | Address
<u>8 CRANFORD ROAD PASADENA, MD</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARCINOMA LIVER</u>
DUE TO (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____
DUE TO (b) _____
DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE</u>
INTERVAL BETWEEN ONSET AND DEATH
<u>3 21/2 YRS</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>12/22, 1957</u> to <u>1/13, 1960</u> , that I last saw the deceased alive on <u>1/13, 1960</u> , and that death occurred at <u>1:23 P. M.</u> from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>3471 E. S. ALLWOOD ROAD PASADENA, MD</u> DATE SIGNED <u>1/13/60</u> | | | | | | | |
| ACTUAL SIGNATURE <u>J. Brady Smith</u> M. D. | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>BRADY SMITH</u> <u>PASADENA, MD</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | | | 22b. DATE THEREOF
<u>1-16-1960</u> | | | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>LEONARD PARK CEM</u> | | | | 22d. LOCATION (City, town, or county) (State)
<u>PASADENA, MD</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>J. H. Brady Smith</u> | | | | 24. REC'D BY REGISTRAR
DATE <u>JAN 15 '60</u> | | | |
| 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Thomas</u> | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

00170

0181

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Anne Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Crownsville</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Baltimore</u> | |
| c. LENGTH OF STAY IN 1b
<u>5mo. 4 days</u> | | d. STREET ADDRESS
<u>40 Standard Court</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
<u>Crownsville State Hospital</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
<u>Rhoads Rodney Simon</u> | | 4. DATE OF DEATH
Month <u>1</u> Day <u>10</u> Year <u>1960</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>1890?</u> |
| 9. AGE (In years last birthday)
<u>70?</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | 11. IF UNDER 24 HRS.
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Unknown</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u> </u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Garfield Davenport</u> | | 14. MOTHER'S MAIDEN NAME
<u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
<u>Unknown</u> | |
| INFORMANT
<u>Hospital Records</u> | | Address
<u> </u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u>
<u>422.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO
(c) DUE TO | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Chronic Brain Syndrome due to Arteriosclerosis - Amputation of left leg</u> | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u> </u> | | 20c. TIME OF INJURY Month, Day, Year
Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u> | |
| 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u> </u> | |
| 20f. (City or town)
<u> </u> | | (County)
<u> </u> (State)
<u> </u> | |
| 21. I certify that I attended the deceased from <u>8/6</u> 19 <u>59</u> to <u>1/10</u> 19 <u>60</u> , that I last saw the deceased alive on <u>1/10</u> 19 <u>60</u> and that death occurred at <u>5:10A</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Hildebrand Heard Reissman</u> M.D. | | ADDRESS (Street, city or town, state)
<u>Crownsville State Hospital, Md.</u> | |
| DATE SIGNED
<u>1/11/60</u> | | 22. LOCATION (City, town, or county) (State)
<u>Baltimore Md.</u> | |
| PHYSICIAN'S NAME (Type)
<u>Hildebrand Heard Reissman, M.D.</u> | | 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>1-15-59</u> | |
| 22b. DATE THEREOF
<u>1-15-59</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Md. Auburn</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Harold & Mauch</u> | | 24a. REC'D BY REGISTRAR
DATE <u>JAN 14 '60</u> | |
| ADDRESS
<u>918 D. Hill</u> | | 24b. REGISTRAR'S SIGNATURE
<u>William L. Thomas</u> | |

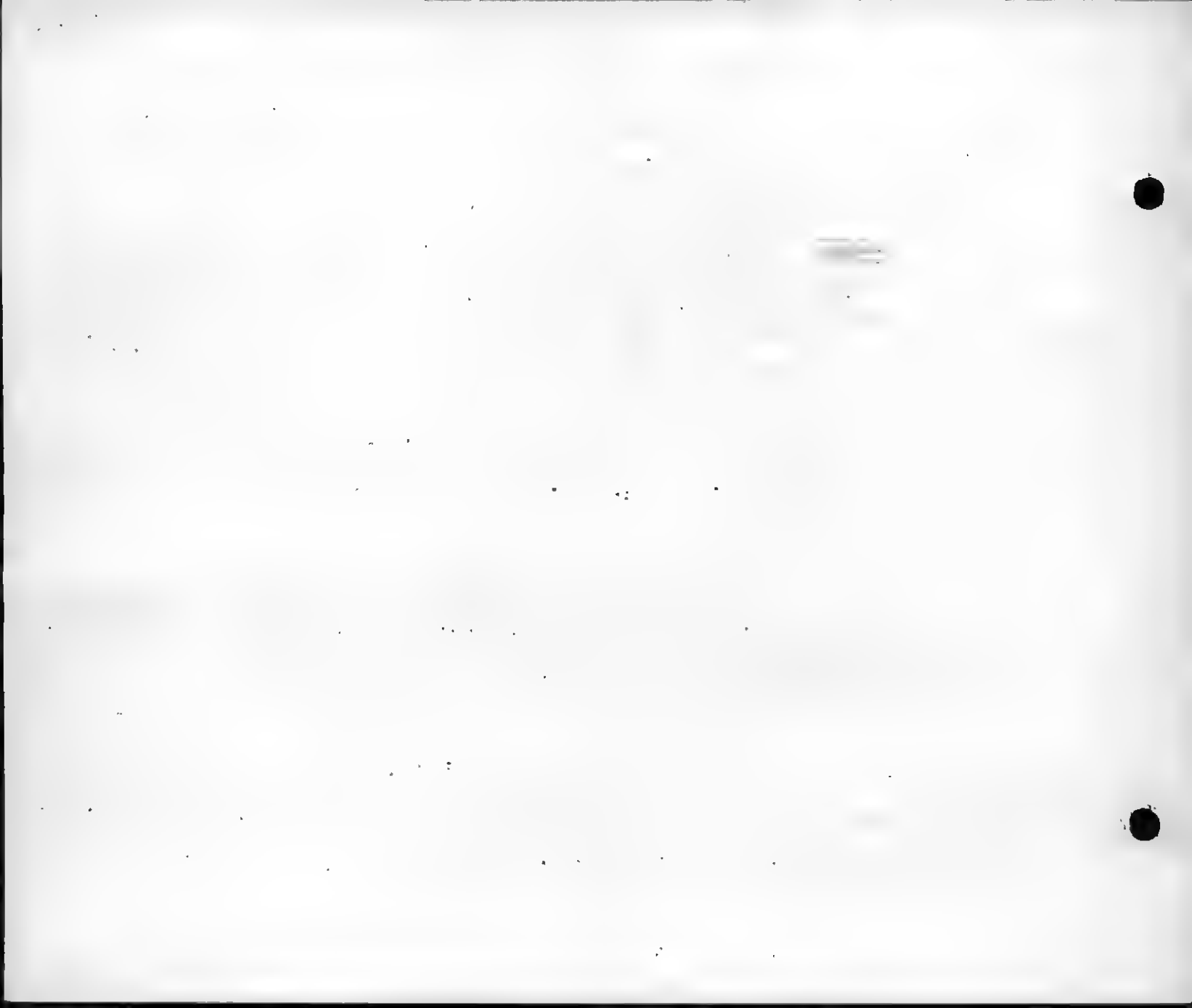
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1 Page 4 TO HOSPITAL: The low requires that the death certificate be executed within 24 hours of death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. VS A15 (4) 15M 9/58 0142 Item 22b, File Q-255 1/29/60.cac. 00171 1 Page 4 TO HOSPITAL: The low requires that the death certificate be executed within 24 hours of death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. VS A15 (4) 15M 9/58

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|-------------------------------|--|--|
| 1 PLACE OF DEATH
a. COUNTY <i>Anne Arundel</i> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Burien Beach</i> | | c. LENGTH OF STAY IN 1b <i>2 years</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Greenway RD. 8476</i> | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Burien Beach</i> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <i>ELLA VIRGINIA MURPHY</i> | | 4. DATE OF DEATH Month Day Year <i>January 27 1960</i> | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>March 14, 1889</i> |
| 9. AGE (In years last birthday) <i>72</i> yrs. | | 10. UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>None</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Beth Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>Hansen Edenfield</i> | | 14. MOTHER'S MAIDEN NAME <i>IDA KIRWAN</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | |
| 17. INFORMANT Address <i>MRS. MARGARET HARRISON - PASADENA, MD.</i> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>arteriosclerotic Cardio-vascular disease</i>
<i>422.1</i> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Generalized arteriosclerosis</i> DUE TO
(c) <i>3 years</i> | | INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Acute virus infection</i> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day Year Hour a. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>Dec. 1, 1957</i> to <i>January 27, 1960</i> , that I last saw the deceased alive on <i>January 26, 1960</i> , and that death occurred at <i>9:00 A.M.</i> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>Randall M. McLaughlin</i> | | ADDRESS (Street, city or town, state) <i>P.O. Box 442 Pasadena, Md.</i> DATE SIGNED <i>Jan. 27, 1960</i> | |
| PHYSICIAN'S NAME (Type) <i>R.M. McLaughlin</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 22b. DATE THEREOF <i>12/30/60</i> | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>Loudon Park Cemetery</i> | | 22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. J. Tucker & Sons</i> ADDRESS <i>Balto - 17, Md.</i> | | 24a. REC'D BY REGISTRAR <i>JAN 29 '60</i> 24b. REGISTRAR'S SIGNATURE <i>Arthur S. K...</i> | |



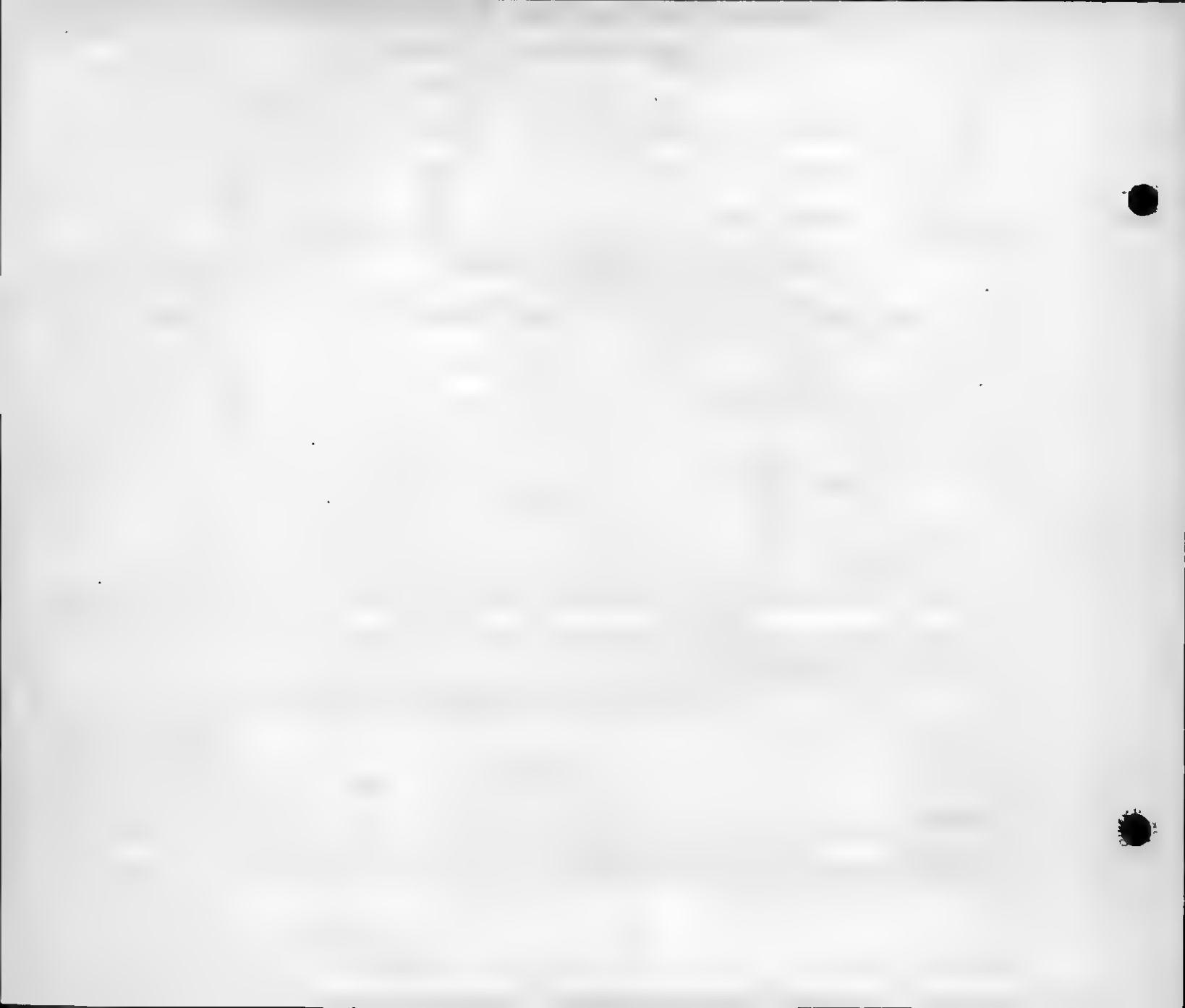
0133 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>CC</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>CC</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | | c. LENGTH OF STAY IN 1b <u>10</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>12 Cathedral St.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>E.</u> Last <u>Myers</u> | | 4. DATE OF DEATH Month <u>1-</u> Day <u>25</u> Year <u>1960</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Apr. 22 - 1875</u> |
| 9. AGE (In years last birthday) <u>84</u> yrs. | | 10. IF UNDER 1 YEAR: Months <u>8</u> Days <u>4</u> Hours <u>15</u> Min <u>00</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Annapolis Md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>John Scible</u> | | 14. MOTHER'S MAIDEN NAME <u>Georganna Williams</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>-</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>-</u> | |
| 17. INFORMANT <u>J. Dery Myers</u> | | Address <u>(2)</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>BRONCHO PNEUMONIA</u>
<u>491X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>-</u> DUE TO (c) <u>-</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>APRIL 1955</u> to <u>JAN 1960</u> , that I last saw the deceased alive on <u>25 JAN 1960</u> , and that death occurred at <u>11 P</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Edward J. Park</u> M.D. | | DATE SIGNED <u>1/26/60</u> | |
| PHYSICIAN'S NAME (Type) <u>Annapolis, Md</u> | | | |
| 22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>1-27-60</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Carver Bluff Cent</u> | 22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sun</u> | | ADDRESS <u>Annapolis Md</u> | |
| 24a. REC'D BY REGISTRAR <u>JAN 28 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knap</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

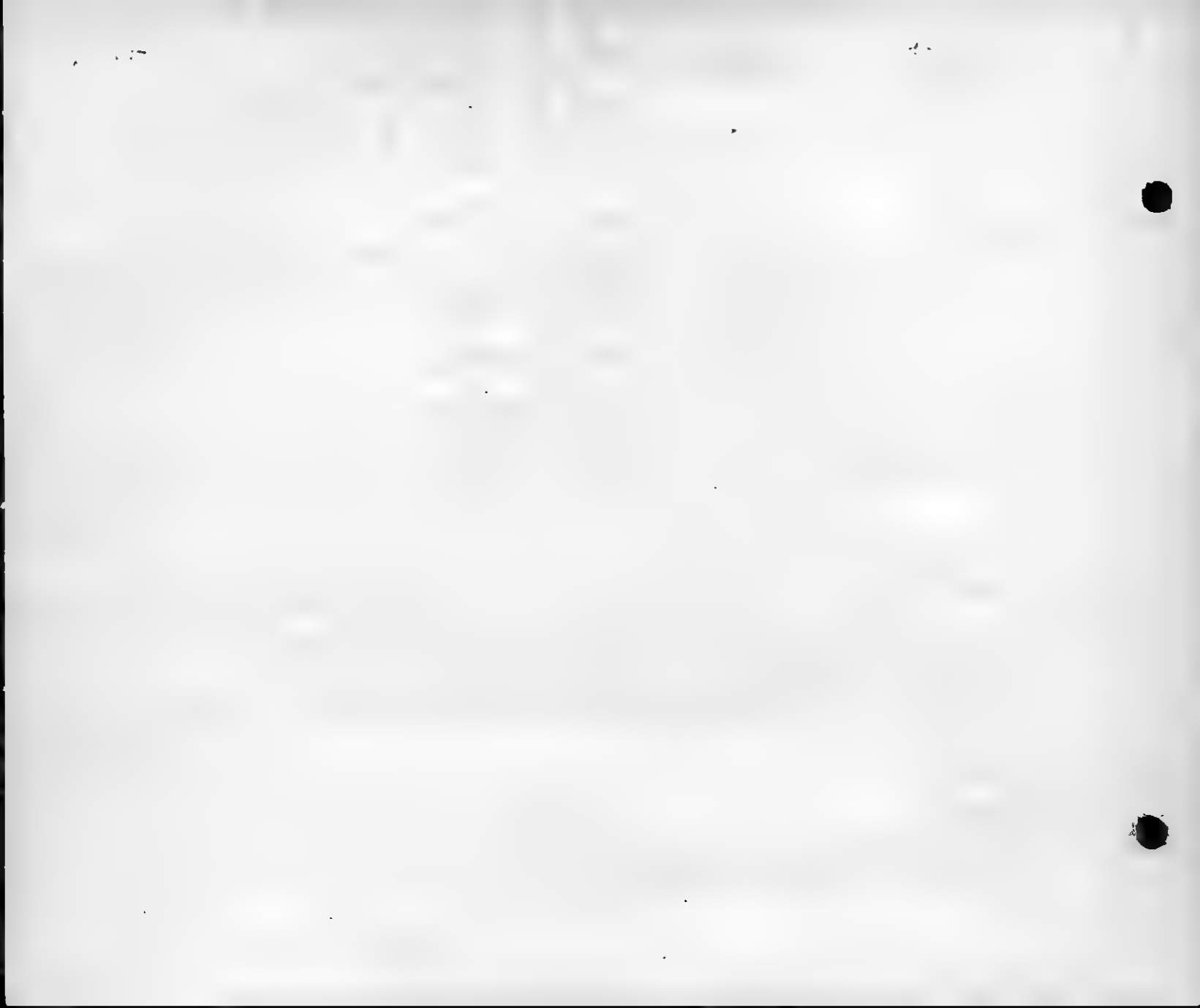
Reg. Dist. No.

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Anne Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1603 Kimber Road</u> | | d. STREET ADDRESS <u>1603 Kimber Road</u> | |
| 3. NAME OF DECEASED (Type or print) <u>ALLEN GREN NEALL</u> | | 4. DATE OF DEATH
Month <u>1</u> Day <u>18</u> Year <u>1960</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11 July 1910</u> |
| 9. AGE (In years last birthday) <u>49</u> yrs. | | 10. IF UNDER 1 YEAR: Months <u>4</u> Days <u>18</u> Hours <u>15</u> Min. <u>00</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Dept. Exp. Sec. of Md.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Walter R. Neall</u> | | 14. MOTHER'S MAIDEN NAME <u>Grace McKinley</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>W.W.II</u> | | 16. SOCIAL SECURITY NO. <u>215-07-3181</u> | |
| 17. INFORMANT <u>Mrs. Dorothy M. Newshaw</u> | | Address <u>Same As #2</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>
<u>420.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO
(c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH
<u>15 min.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>June 1953</u> to <u>January 1960</u> , that I last saw the deceased alive on <u>January 10, 1960</u> , and that death occurred at <u>11 P. M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>C. R. MacDonald</u> M.D. | | ADDRESS (Street, city or town, state) <u>204 Green Hill Rd. Glen Burnie Md.</u> | |
| DATE SIGNED <u>1-19-60</u> | | | |
| PHYSICIAN'S NAME (Type) <u>C. R. MacDonald</u> | | <u>Glen Burnie, Md.</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>22 Jan. 1960</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Balto. Nat'l Cem.</u> | 22d. LOCATION (City, town, or county) (State) <u>Balto. Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>R. V. Singleton</u> | | ADDRESS <u>Glen Burnie, Md.</u> | |
| 24a. REC'D BY REGISTRAR <u>DATE JAN 25 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knead</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0184 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00175

| | | | | | | | |
|--|--|---|---|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Same b. COUNTY Same | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Ferndale | | | c. LENGTH OF STAY IN 1b
3 years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Same | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
201 Ferndale Avenue | | | | d. STREET ADDRESS
Same | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED WLADYSLAW First Wlasydaw Middle Olszewski Last | | | | 4. DATE OF DEATH January 23rd. 19 60 | | | |
| 5. SEX
M | | 6. COLOR OR RACE
W. | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
? | |
| 9. AGE (In years last birthday)
90 ? yrs. | | 10. UNDER 1 YEAR
Months ? Days ? | | 11. UNDER 24 HRS
Hours ? Min. ? | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired stevedore | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Poland Europe | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
? | | | | 14. MOTHER'S MAIDEN NAME
? | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
218-0701143 | | 17. INFORMANT Mr. John Olszewski (Son) Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) General Arteriosclerosis
450.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ? DUE TO (c) ?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ? | | | | | | | |
| INTERVAL BETWEEN ONSET AND DEATH
Many years. | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour 19 a. m. ? p. m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE <i>Gustave H. Faubert</i> | | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| NAME (Type) Gustave H. Faubert, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 1/23/60 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
1/26/60 | | 22c. NAME OF CEMETERY OR CREMATORY
St. Stanislaus Cem. | | 22d. LOCATION (City, town, or county) (State)
Baltimore Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<i>Frank W. Olszewski</i> | | | | 24a. REC'D BY REGISTRAR
1930 Eastern Ave | | 24b. REGISTRAR'S SIGNATURE
<i>Arthur L. Hume</i> | |

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



0134 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | |
|---|-------------------------------|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>aa</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Md</u> b. COUNTY <u>aa</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>154 King George St.</u> | | e. STREET ADDRESS <u>154 King George St.</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>GUSTAV RUDOLF WILHELM PAAR</u> Middle <u>PAAR</u> Last <u>PAAR</u> | | 4. DATE OF DEATH Month <u>1</u> Day <u>30</u> Year <u>1960</u> | | | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11-25-1890</u> | | |
| 9. AGE (In years last birthday) <u>69</u> yrs. | | 10. IF UNDER 1 YEAR: Months <u>30</u> Days <u>30</u> Hours <u>19</u> Min. <u>60</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Ret.</u> | | | |
| 11. BIRTHPLACE (State or foreign country) <u>Germany</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | |
| 13. FATHER'S NAME <u>Unknown</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>nc</u> | | | |
| 17. INFORMANT <u>Viva Head Paar</u> | | Address <u>#2</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u>
<u>420.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>420.1</u> DUE TO (c) <u>420.1</u>
INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> | | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></u> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>o. m.</u> <u>19</u> p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | 21. I certify that I attended the deceased from <u>1/6</u> 19 <u>60</u> , to <u>1/30</u> 19 <u>60</u> , that I last saw the deceased alive on <u>1/27/60</u> , and that death occurred at <u>9:55 AM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Richard N. Peeler</u> M.D. | | ADDRESS (Street, city or town, state) <u>121 Cathedral St - Annapolis, Md.</u> DATE SIGNED <u>1/30/60</u> | | | |
| PHYSICIAN'S NAME (Type) <u>RICHARD N. PEELER</u> | | 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> | | | |
| 22b. DATE THEREOF <u>2-1-60</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u> | | 22d. LOCATION (City, town, or county) (State) <u>Prince George Co. Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. G. ...</u> ADDRESS <u>Annapolis, Md.</u> | | 24a. REC'D BY REGISTRAR <u>DATE FEB 2 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Charles E. ...</u> | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

00177

0185

| | | | | | | | |
|---|----------------------------------|---|-------------------------------------|---|--|---|---|
| 1 PLACE OF DEATH
a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u> | | | | 2 USUAL RESIDENCE (Where deceased lived If institution- Residence before admission)
a. STATE <u>Same</u> b. COUNTY <u>Same</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Glen Burnie</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Same</u> | | | |
| c. LENGTH OF STAY IN 1b
<u>3 1/2</u> years | | | | d. STREET ADDRESS
<u>Same</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION
<u>231 St. James Drive</u> | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Lilia</u> Middle <u>Peters</u> Last <u></u> | | | | 4. DATE OF DEATH
Month <u>January</u> Day <u>30th.</u> Year <u>19 60</u> | | | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>11/22/72</u> | | 9. AGE (In years last birthday)
<u>87</u> yrs | IF UNDER 1 YEAR
Months <u></u> Days <u></u> | IF UNDER 24 HRS
Hours <u></u> Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired Char Woman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>Baltimore, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Frank Peters</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Elizabeth Catherine Nichols</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
<u></u> | | 16. SOCIAL SECURITY NO.
<u></u> | | 17. INFORMANT Address
<u>Mr. Lawrence Busch, 231 St. James Drive, Glen Burnie, Md.</u> | | | |
| 18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>General Arteriosclerosis</u>
<u>450.0</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u></u> DUE TO (c) <u></u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>?</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>January 25, 1960</u> to <u>January 30, 1960</u> that (I) (we) last saw the deceased alive on <u>1/29/60</u> 19 <u>60</u> , and that death occurred at <u>4</u> AM, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Gustave H. Faubert, M.D.</u> M.D. | | | | ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> | | 22b. DATE SIGNED
<u>1/30/60</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Gustave H. Faubert, M.D.</u> | | | | 22d. ADDRESS
<u>Glen Burnie, Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>2/2/60</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>New Cathedral Cemetery</u> | | 23d. LOCATION (City, town, or county) (State)
<u>Baltimore, Maryland</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>Leonard J. Ruck</u> | | | | ADDRESS
<u>5305 Harford Road #14</u> | | 25a. REC'D BY REGISTRAR
DATE <u>FEB 3 '60</u> | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
<u>Arthur L. Kraus</u> | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00178

| | | | | | | | | | | | | | | | | | | | | | |
|---|--|---|--|--|--|---|--|--|--|--|--|---|--|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Pasadena | | c. LENGTH OF STAY IN 1b
Life | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE Same | | b. COUNTY Same | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Same | | d. STREET ADDRESS
Same | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Route 9 Box 213 | | 3. NAME OF DECEASED
(Type or print)
William Rodell Pinkard | | 4. DATE OF DEATH
Month January Day 5th Year 1960 | | 5. SEX
M. | | 6. COLOR OR RACE
C. | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
9/28/59 | | 9. AGE (in years last birthday)
3 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 11. BIRTHPLACE (State or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
William Pinkard | | 14. MOTHER'S MAIDEN NAME
Josephine Morgan | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
William Pinkard (Father). | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Infection of the respiratory tract.
527.2 DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town)
(County)
(State) | | 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
1-8-60 | | 22c. NAME OF CEMETERY OR CREMATORY
HALS NIK HUIST CHURCH | | 22d. LOCATION (City, town, or county)
MARLEY MICK Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Joseph L. Brown + Son | | ADDRESS
108 W. Montgomery | | 24a. REC'D BY REGISTRAR
DATE JAN 10 1960 | | 24b. REGISTRAR'S SIGNATURE
1/5/60 | | 24c. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 24d. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | 24e. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED
1/5/60 | | | | | | | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

38192XV3



FOR STATE
HEALTH DEPT.

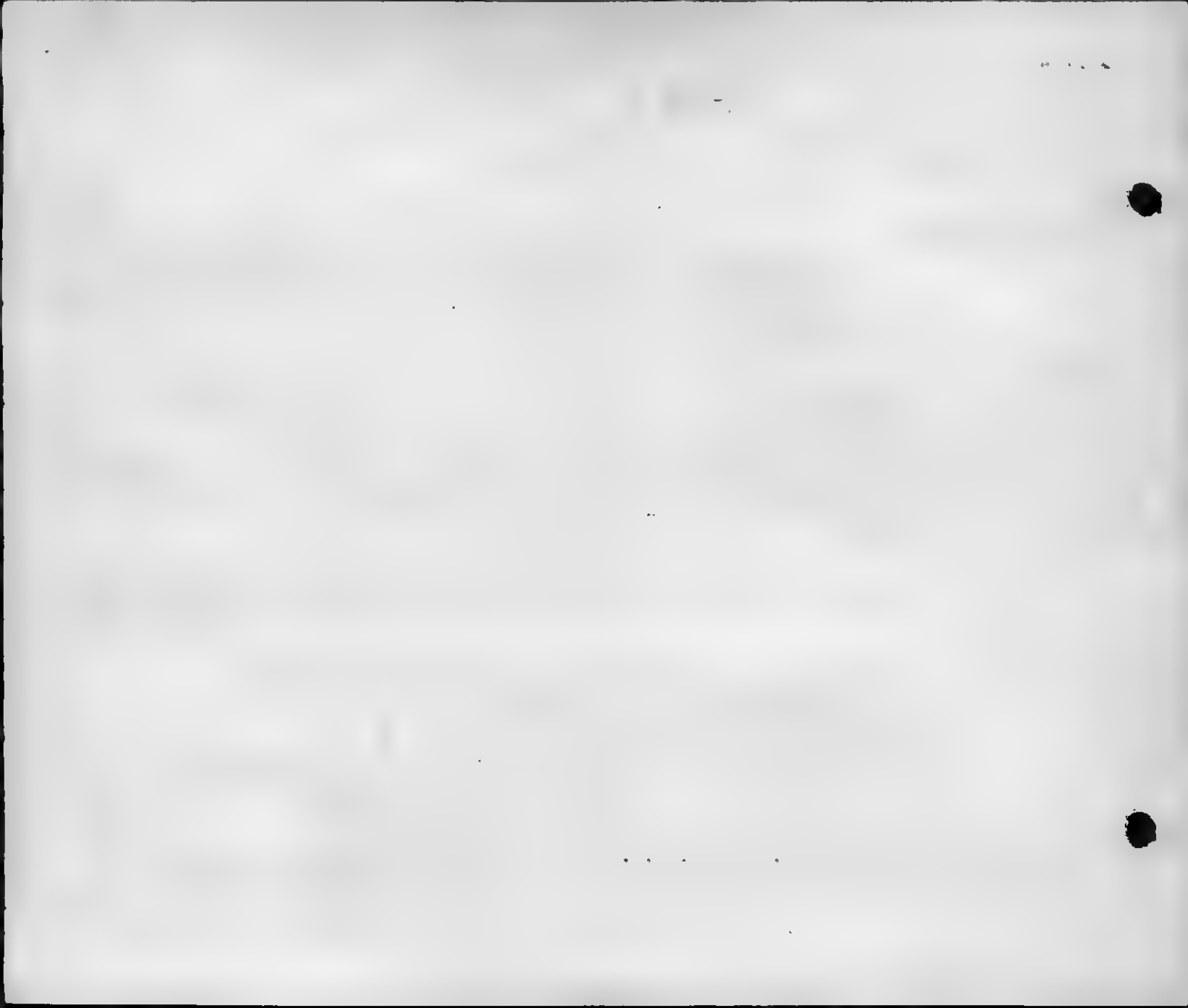
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the items are necessary, the items should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01522

| | | | | | | | |
|--|-------------------------------|--|---------------------------------------|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Howard | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ANNAPOLIS | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hanover | | | |
| c. LENGTH OF STAY IN IL D, O, A. | | | | d. STREET ADDRESS Hawkins Drive | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Anne Arundel General Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) PATRICIA ANN QUINN | | First Middle Last | | 4. DATE OF DEATH January 31 February 2 1960 | | Month Day Year | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 21, 1959 | 9. AGE (In years last birthday) 1 7 1 | | IF UNDER 1 YEAR: Months Days | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Baltimore Md | |
| 12. CITIZEN OF WHAT COUNTRY? USA | | | | 13. FATHER'S NAME BERNARD QUINN | | | |
| 14. MOTHER'S MAIDEN NAME PEGGY Fuchs | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | | |
| 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT BERNARD QUINN, - SAME AS 2 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Massive aspiration of stomach content complicating
gastro-enteritis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) gastro-enteritis | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE Russell S. Fisher M.D. | | | | CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) Russell S. Fisher, M.D. | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | DATE SIGNED 2/1/60 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | | 22b. DATE THEREOF 2-3-60 | | 22c. NAME OF CEMETERY OR CREMATORY Glen Haven | |
| 22d. LOCATION (City, town, or country) Glen Burnie Md | | | | 22e. REC'D BY REGISTRAR FEB 4 '60 | | | |
| 23. FUNERAL DIRECTOR Hopping & Kirmser | | | | 24b. REGISTRAR'S SIGNATURE Arthur S. Kirmser | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00179

0187

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|-------------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Baltimore</u> <u>Anne Arundel</u> <u>MARYLAND</u> | | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>AD</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Linthicum Heights</u> | | c. LENGTH OF STAY IN 1b
<u>X</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Linthicum Heights</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>300 Greenwood Road</u> | | d. STREET ADDRESS
<u>300 Greenwood Road</u> | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
<u>JOHN</u> <u>A.</u> <u>REILLY</u> | | 4. DATE OF DEATH
Month <u>Jan</u> Day <u>16</u> Year <u>1960</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Oct. 10, 1889</u> |
| 9. AGE (In years lost birthday)
<u>70</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | IF UNDER 24 HRS
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired-Adjudication Officer-Veterans Admin.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Massachusetts</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Massachusetts</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u> </u> | |
| 13. FATHER'S NAME
<u>John O'Reilly</u> | | 14. MOTHER'S MAIDEN NAME
<u>Mary Ann ?</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service)
<u>Yes</u> <u>World War I</u> | | 16. SOCIAL SECURITY NO.
<u>None</u> | |
| 17. INFORMANT
<u>Mrs. Mabel F. Reilly-300 Greenwood Road</u> | | Address
<u> </u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardio-Vascular Disease</u>
<u>422.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
<u> </u> | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. <u> </u> p. m. <u> </u> 19 <u>60</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u> </u> | | 20f. (City or town) (County) (State)
<u> </u> | |
| 21. I certify that I attended the deceased from <u>Jan 16, 1960</u> to <u>Jan 16, 1960</u> , that I last saw the deceased alive on <u>Jan 16, 1960</u> , and that death occurred at <u>11:00 P.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
<u>Chas. L. Ball Jr.</u> M.D. | | ADDRESS (Street, city or town, state)
<u>203 W. Maple Rd. Linthicum Md.</u> | |
| DATE SIGNED
<u>1/17/60</u> | | | |
| PHYSICIAN'S NAME (Type)
<u>CHARLES L. BALL, JR.</u> | | | |
| 22a. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | 22b. DATE THEREOF
<u>1/21/60</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>St. Patricks Cemetery</u> | 22d. LOCATION (City, town, or county) (State)
<u>Wareham, Mass.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Wm. J. Tichenor & Sons</u> | | ADDRESS
<u>Baltimore 17, Md.</u> | |
| 24a. REC'D BY REGISTRAR
<u>JAN 18 '60</u> | | 24b. REGISTRAR'S SIGNATURE
<u> </u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

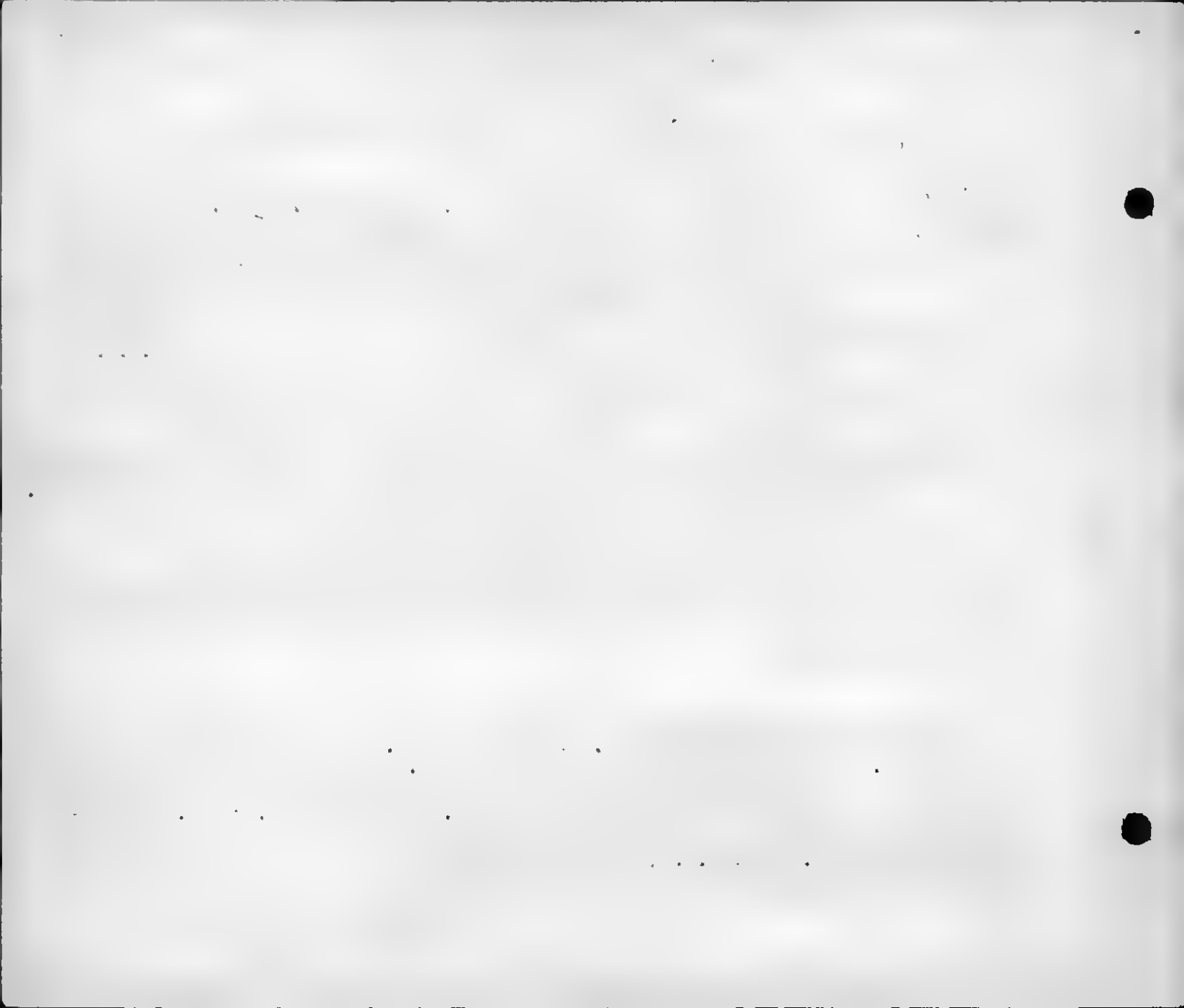
Reg. Dist. No.

0188

| | | | | | |
|---|----------------------------------|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Ann Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission)
a. STATE <u>131 Maryland</u>
b. COUNTY <u>Baltimore</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Glen Burnie</u> | | c. LENGTH OF STAY IN 1b
<u>14 days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Plaza Manor Nursing Home</u> | | d. STREET ADDRESS
<u>131 N. Aisquith St. Balto.2</u> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Rosa Mae</u> Middle <u>Ricks</u> Last <u>Ricks</u> | | 4. DATE OF DEATH
Month <u>January</u> Day <u>22</u> Year <u>1960</u> | | | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>May 12, 1909</u> | | |
| 9. AGE (In years last birthday)
<u>50</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Unknown</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Unknown</u> | | | |
| 11. BIRTHPLACE (State or foreign country)
<u>Unknown N.C.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | |
| 13. FATHER'S NAME
<u>Unknown Willie Ricks</u> | | 14. MOTHER'S MAIDEN NAME
<u>Unknown Minnie Ricks</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>213-09-5119</u> | | | |
| 17. INFORMANT
<u>Deceased</u> | | Address <u> </u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Inoperable carcinoma lungs</u>
<u>163x</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | INTERVAL BETWEEN ONSET AND DEATH
<u>about 1 yr.</u> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u> </u> | |
| 20f. (City or town)
<u> </u> | | 20g. (County)
<u> </u> | | 20h. (State)
<u> </u> | |
| 21. I certify that I attended the deceased from <u>Jan. 8, 1960</u> to <u>Jan. 22, 1960</u> , that I last saw the deceased alive on <u>Jan. 16, 1960</u> , and that death occurred at <u>4 A. M.</u> from the causes and on the date stated above. | | | | | |
| ADDRESS (Street, city or town, state) <u>400 N. Carrollton Ave. Balto.23</u> DATE SIGNED <u>1-22-1960</u> | | | | | |
| ACTUAL SIGNATURE <u>James M. Pair</u> M.D. | | | | | |
| PHYSICIAN'S NAME (Type) <u>James M. Pair, M.D.</u> <u>Maryland</u> | | | | | |
| 22a. BURIAL, CREMATION, 22b. DATE THEREOF
(Specify)
<u>21-22-60</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>St. Mary's Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Baltimore, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>William Reese, Jr.</u> | | ADDRESS
<u> </u> | | 24a. RECEIVED BY REGISTRAR
DATE <u>JAN 27 60</u> | |
| 24b. REGISTRAR'S SIGNATURE
<u>William D. Hanes</u> | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



0189

CERTIFICATE OF DEATH

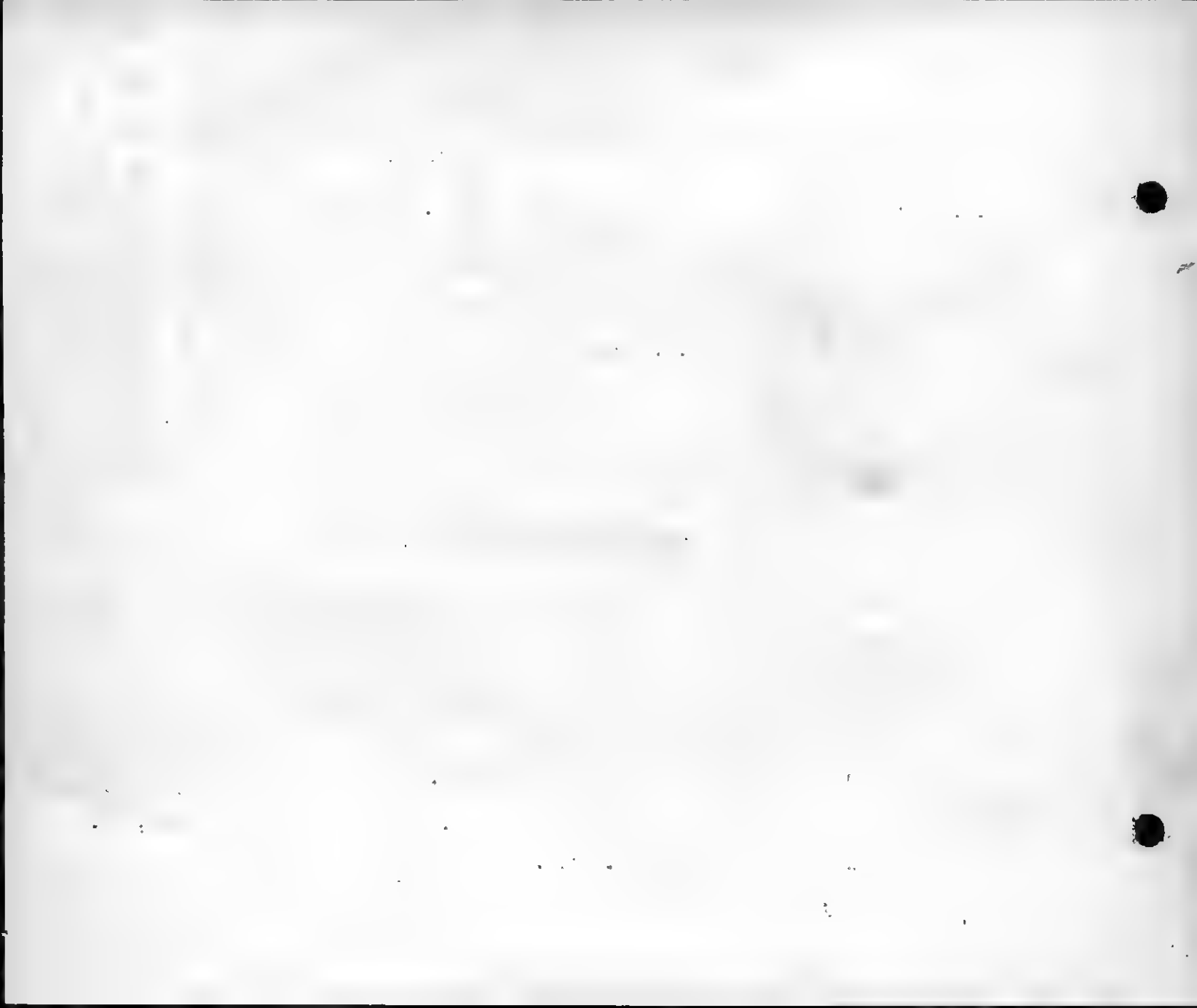
Reg. Dist. No. 27

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY
Anne Arundel
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort George G Meade
c. LENGTH OF STAY IN lb
U.S. Army Hospital | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE
Maryland
b. COUNTY
Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore
d. STREET ADDRESS
133 S. Loudon Ave
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
SHELBY A ROBBINS | | | | 4. DATE OF DEATH
Month Day Year
January 17 1960 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
Cau | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
20 April 1880 | |
| 9. AGE (In years last birthday)
79 yrs | | 10. F UNDER 1 YEAR
Months Days Hours Min. | | 11. BIRTHPLACE (State or foreign country)
Tenn. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | | | 10b. KIND OF BUSINESS OR INDUSTRY
U.S. Army | | 11. BIRTHPLACE (State or foreign country)
Tenn. | |
| 13. FATHER'S NAME
UNKNOWN | | | | 14. MOTHER'S MAIDEN NAME
UNKNOWN | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no or unknown) (If yes, give war or dates of service)
YES 1898-1928 | | | | 16. SOCIAL SECURITY NO.
- | | | |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)
Heart Failure
527.2 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Chronic lung disease
DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
10 years | | | | INTERVAL BETWEEN ONSET AND DEATH
2 days | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY
Month Day Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 0800 17 Jan 60 , to 60 , that I last saw the deceased alive on 17 Jan 60 , and that death occurred at 2:40 PM , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 17 Jan 60 SIGNED | | | | | | | |
| ACTUAL SIGNATURE
Stanley Siegelman | | | | M.D. U.S. Army Hosp Ft Geo G Meade, Md. | | | |
| PHYSICIAN'S NAME (Type)
STANLEY SIEGELMAN, Capt., M.C. | | | | | | | |
| 22a. BURIAL, CREMATION, or other disposal (Specify)
Burial | | 22b. DATE THEREOF
1/20/60 | | 22c. NAME OF CEMETERY OR CREMATORY
BALTO. NAT. CEM. | | 22d. LOCATION (City, town, or county) (State)
BALTO. Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
G. Truman Schuch | | | | ADDRESS
3512 Fred. Ave. | | 24a. REC'D BY REGISTRAR
JAN 20 60 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Arthur L. Frank | | | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

00182

0190

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Millersville</u> | | | | c. LENGTH OF STAY IN 1b
<u>3 yrs.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Box 83 RTE 2 Millersville Md.</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>WALTER</u> Middle <u>MAX</u> Last <u>RUDORF</u> | | | | 4. DATE OF DEATH
Month <u>Jan</u> Day <u>17</u> Year <u>1960</u> | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Dec. 28 1885</u> | |
| 9. AGE (In years last birthday)
<u>74</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u> | | IF UNDER 24 HRS
Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Cylinder Press Man U.S. Lithograph</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Germany</u> | | 11. BIRTHPLACE (State or foreign country)
<u>USA</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | | | | | | |
| 13. FATHER'S NAME
<u>Tristian Rudolf</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Sylvia Semon</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO.
<u> </u> | | 17. INFORMANT
<u>Annie Rudolf</u> Address <u>Box 83 Rte 2</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Hypertensive Cardio Vascular Dis</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis</u>
DUE TO
(c) <u> </u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>3 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u> | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I attended the deceased from <u>March 1957</u> to <u>January 1960</u> that I last saw the deceased alive on <u>January 11, 1960</u> and that death occurred at <u>12:30 PM</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>C.R. MacDonald M.D.</u> M.D. <u>204 Creis Hwy. Glen Burnie 1-17-60</u> | | | | DATE SIGNED | | | |
| PHYSICIAN'S NAME (Type) <u>C.R. MacDonald M.D.</u> <u>Glen Burnie Maryland</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>Jan 19 1960</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Glen Haven Mem Park</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Glen Burnie Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping & Kirkley Funeral Home</u> ADDRESS <u>Glen Burnie</u> | | | | 24a. REC'D BY REGISTRAR
<u>JAN 20 '60</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kline</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



0191

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Anne Arundel</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u>
b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u> | | c. LENGTH OF STAY IN 1b <u>48 yrs</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Viola</u> Middle <u>Lumanta</u> Last <u>Saunders</u> | | 4. DATE OF DEATH
Month <u>1</u> Day <u>30</u> Year <u>1960</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>C</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH <u>9/13/93</u> |
| 9. AGE (In years last birthday) <u>66</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>housekeeper</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Dave Saunders</u> | | 14. MOTHER'S MAIDEN NAME <u>Emma Taylor</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>none?</u> | |
| 17. INFORMANT <u>Medical Record</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Heart Failure</u>
<u>450.0</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>General Arteriosclerosis</u>
DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>Oct 23, 1958</u> , to <u>1-30-1960</u> , that I last saw the deceased alive on <u>1-30-1960</u> , and that death occurred at <u>7:55 P.M.</u> from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| ACTUAL SIGNATURE <u>Carl B. Schleifer</u> M.D. <u>CROWNVILLE STATE HOSP</u> | | | |
| PHYSICIAN'S NAME (Type) <u>CARL B. SCHLEIFER M.D. CROWNVILLE MD</u> | | <u>1-31-60</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>Feb 3-1960</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Hagerstown MD</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>John R. Watson Jr.</u> ADDRESS <u>Hagerstown MD</u> | | 24. REC'D BY REGISTRAR <u>FEB 4 '60</u> | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the registrar should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



0192 CERTIFICATE OF DEATH

Reg. Dist. No.

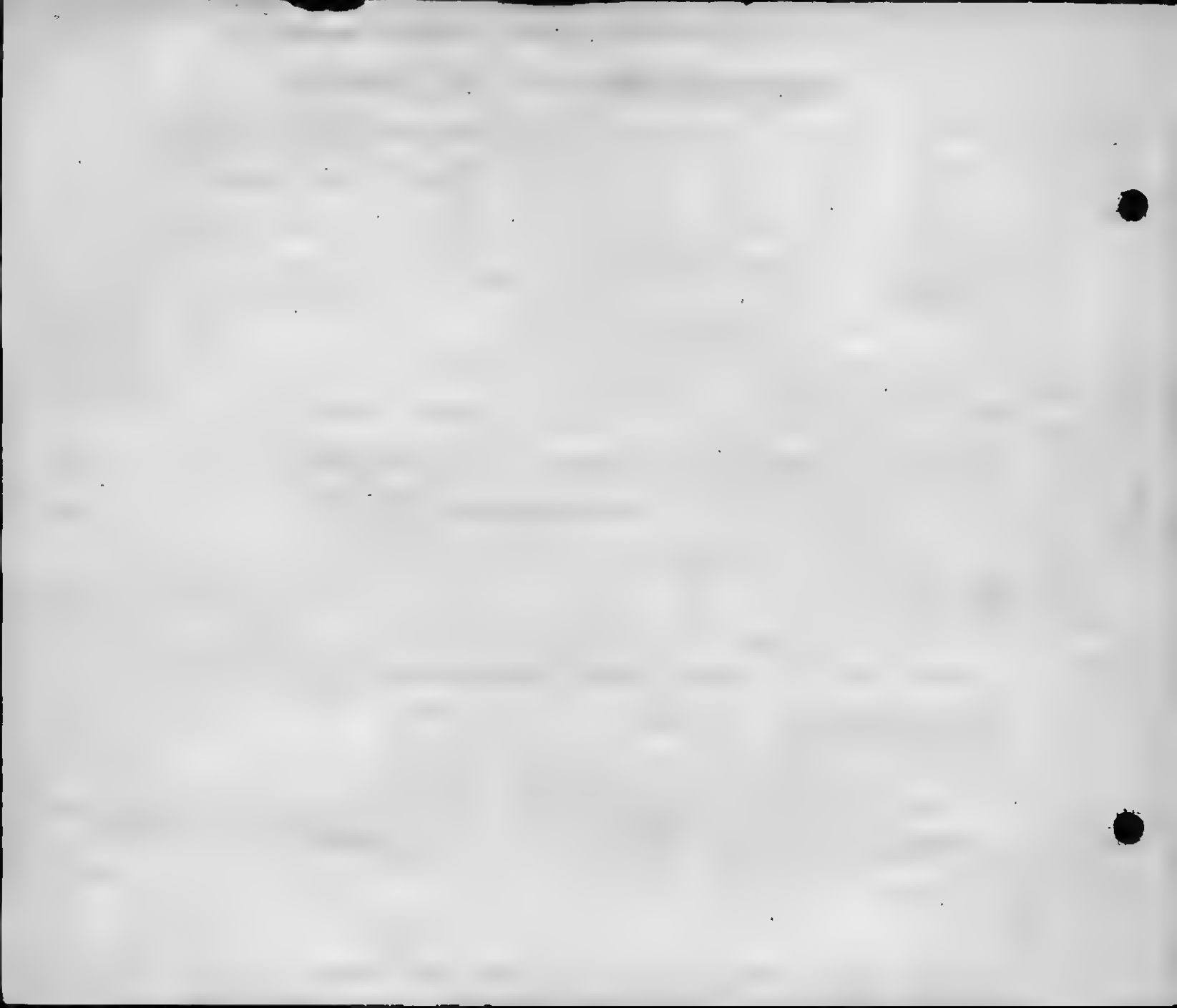
| | | | | | | | |
|---|---|---|---|--|---|---|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>ANNE ARUNDEL</u> | | STATE <u>MARYLAND</u> | | COUNTY <u>ANNE ARUNDEL</u> | | | |
| CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN <u>BAY RIDGE</u> | | LENGTH OF STAY
(In this place) | | CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN <u>BAY RIDGE</u> | | | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS
<u>90 RIVER DRIVE</u> | | | | STREET ADDRESS
<u>90 RIVER DRIVE</u> | | | |
| 3. NAME OF DECEASED
(Type or Print) <u>ELEANOR C. Scott</u> | | | | 4. DATE OF DEATH
(Month) <u>JAN.</u> (Day) <u>13</u> (Year) <u>1960</u> | | | |
| 5. SEX
<u>FEM.</u> | 6. COLOR OR RACE
<u>WHITE</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH
<u>MAY 23, 1878</u> | 9. AGE last birthday
<u>81</u> yrs. | IF UNDER 1 YEAR
Months _____ Days _____ | | IF UNDER 24 HRS.
Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>HOUSEWIFE</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY
— | | 11. BIRTHPLACE (State or foreign country)
<u>PENNSYLVANIA</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> |
| 13. FATHER'S NAME
<u>WILLIAM W. CARSON</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>JENNIE GOULD</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS
<u>MRS CHARLES KEOWN #2</u> | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | | | 16. MEDICAL CERTIFICATION | |
| IMMEDIATE CAUSE (A) <u>450.0</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| ANTECEDENT CAUSE(S) DUE TO <u>Generalized arteriosclerosis</u> | | | | | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B) _____ | | | | | | | |
| DUE TO (C) _____ | | | | | | | |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. MAJOR FINDINGS OF OPERATION | | | |
| | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. PLACE (Home, farm, factory, OF INJURY—street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | |
| | | | | | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | |
| | | | | | | | |
| 22. I hereby certify that I attended the deceased from <u>1.13</u>, 19<u>60</u>, to <u>1.13</u>, 19<u>60</u>, that I last saw the deceased alive on <u>1.13</u>, 19<u>60</u>, and that death occurred at <u>3P</u> M., from the causes and on the date stated above. | | | | | | | |
| SIGNATURE
<u>Frank M. Shilly</u> M.D. 121 Cathedral St. | | | | ADDRESS (Street, city, town, state) | | DATE SIGNED
<u>1.13.60</u> | |
| 23. BURIAL, CREMATION, REMOVAL (Specify)
<u>burial</u> | | DATE THEREOF
<u>1-16-1960</u> | | NAME OF CEMETERY OR CREMATORY
<u>ALLEGHENY MEM.</u> | | LOCATION (City, town, or county) (State)
<u>ALLEGHENY CO. PA.</u> | |
| 24. REC'D BY REGISTRAR | | REGISTRAR'S SIGNATURE
<u>Charles S. Kinn</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE
<u>JOHN M. TAYLOR</u> | | ADDRESS
<u>SON ANNAPOLIS MD.</u> | |
| DATE
<u>JAN 15 '60</u> | | | | | | | |

INSTRUCTIONS

TO ATTENDING PHYSICIAN ON HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

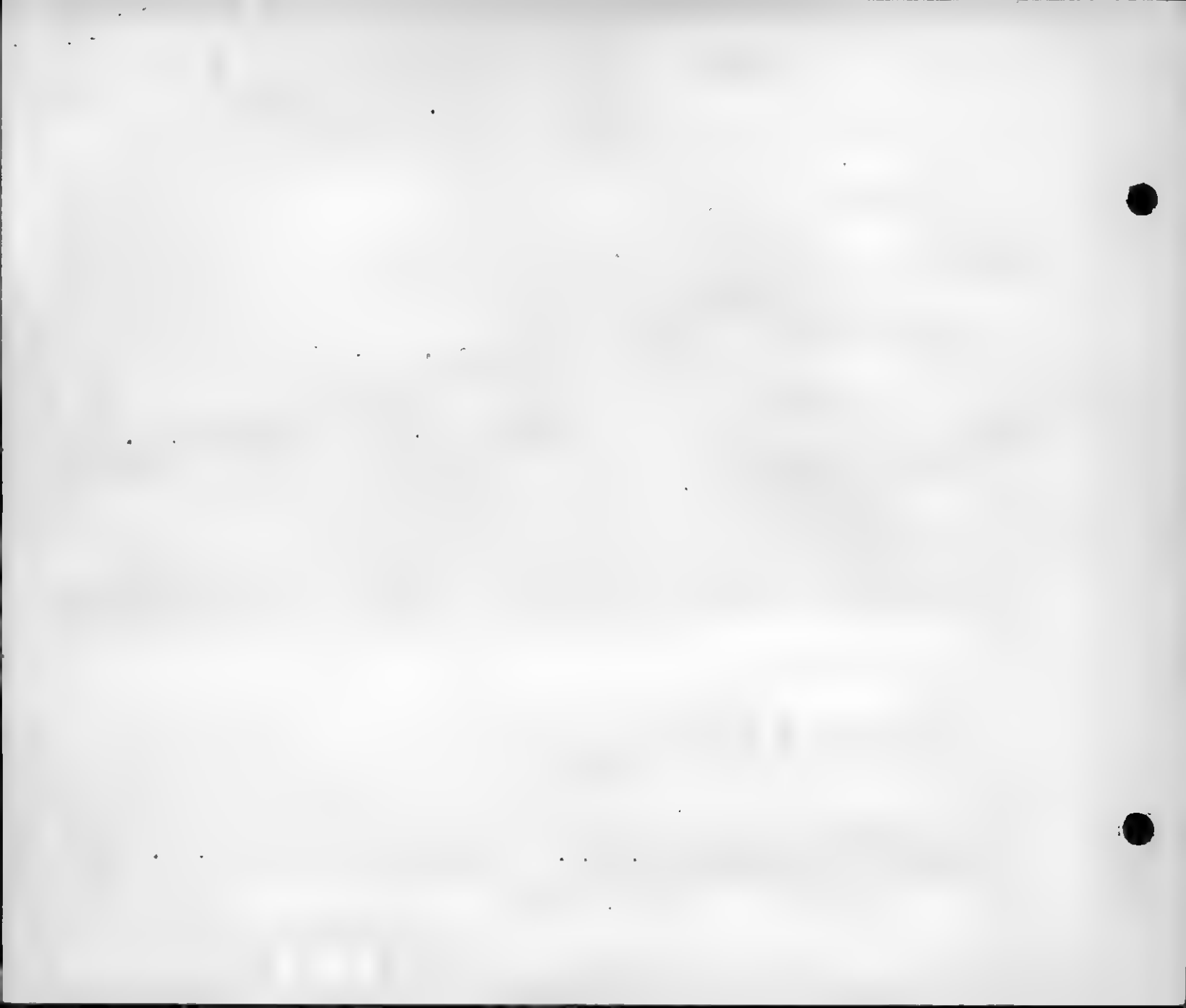
CERTIFICATE OF DEATH

Reg. Dist. No.

27

0193

| | | | |
|---|---------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE Md. b. COUNTY Anne Arundel ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fort George G. Meade | | c. LENGTH OF STAY IN 1b
X Odenton | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
US ARMY HOSPITAL FT GEO. G. MEADE | | d. STREET ADDRESS
Box 127-B | |
| 3. NAME OF DECEASED (Type or print)
First Lloyd Middle L. Last Shafer | | 4. DATE OF DEATH
Month January Day 16 Year 1960 | |
| 5. SEX
Male | 6. COLOR OR RACE
Cauc | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
19 February 1936 |
| 9. AGE (In years lost birthday) yrs. 23 | | 10. IF UNDER 1 YEAR Months Days Hours Min.
IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Soldier | | 10b. KIND OF BUSINESS OR INDUSTRY
US Army | |
| 11. BIRTHPLACE (State or foreign country)
Losage, West, Virginia | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Unk | | 14. MOTHER'S MAIDEN NAME
Unk | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
YES | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | |
| 17. INFORMANT
Personnel Records Ft Geo G Meade, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MULTIPLE INTERNAL INJURIES
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ACTUAL BATTLE ACCIDENT
DUE TO (c) 1 HR 45 MIN | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. p. 0100 Jan 16 60 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Rt 170 | | 20f. (City or town) (County) (State)
Anne Arundel Md | |
| 21. I certify that I attended the deceased from 16 JAN 1960 to 16 JAN 1960 , that I last saw the deceased alive on 16 JAN 1960 , and that death occurred at 1245A M, from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED 16 Jan 60 | | | |
| ACTUAL SIGNATURE Matthew N Harris M.D. | | | |
| PHYSICIAN'S NAME (Type) MATTHEW N HARRIS, Capt., M.C. USA Hospital Ft Geo G Meade, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 22b. DATE THEREOF
1-21-60 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 22d. LOCATION (City, town, or county) (State)
Arlington, Virginia | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Wm. Cook, Inc., 1217 St. Paul Street | | 24a. REC'D BY REGISTRAR
DATE JAN 21 '60 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur S. Evans | | | |



0194

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|----------------------------------|---|---|
| 1 PLACE OF DEATH
a. COUNTY Anne Arundel MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived if institution Residence before admission)
a. STATE Maryland b. COUNTY Anne Arundel | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Ft Geo. G. Meade - US Army Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| f. STREET ADDRESS
7234-D Johnson St. | | | |
| 3 NAME OF DECEASED (Type or print)
First Richard Middle B. Last Shepard | | 4. DATE OF DEATH
Month January Day 21 Year 1960 | |
| 5 SEX
Male | 6. COLOR OR RACE
Cauc. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1897
July 21, 1897 |
| 9 AGE (In years last birthday)
62 yrs. | | 10. IF UNDER 1 YEAR
Months 62 Days 62 Hours 62 Min. | |
| 10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Farmer | | 10b KIND OF BUSINESS OR INDUSTRY
Mississippi | |
| 11. BIRTHPLACE (State or foreign country)
USA | | 12 CITIZEN OF WHAT COUNTRY?
USA | |
| 13 FATHER'S NAME
Jack Shepard | | 14. MOTHER'S MAIDEN NAME
Nannie Kilgore | |
| 15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO.
INFORMANT
(Son) Sgt William Shepard Qtrs 7234-D F.G.M, MD | |
| 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypertension
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic heart disease DUE TO
(c) 4 years
4 years | | INTERVAL BETWEEN ONSET AND DEATH
4 years
4 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 6:07 AM , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Henry N. Claman M.D. | | ADDRESS (Street, city or town, state) West Memphis, Arkansas | |
| DATE SIGNED Jan 25 1960 | | | |
| PHYSICIAN'S NAME (Type) HENRY N. CLAMAN, CAPT MC | | US ARMY HOSPITAL, FORT G. G. MEADE, MD | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
1-23-60 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Bassett Cemetery | | 22d. LOCATION (City, town, or county) (State)
West Memphis, Arkansas | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John M. Weber & Sons Inc.
401 S. Chester St. | | 24a. REC'D BY REGISTRAR
Jan 25 1960 | |
| 24b. REGISTRAR'S SIGNATURE
C. J. H. H. | | | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0195 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

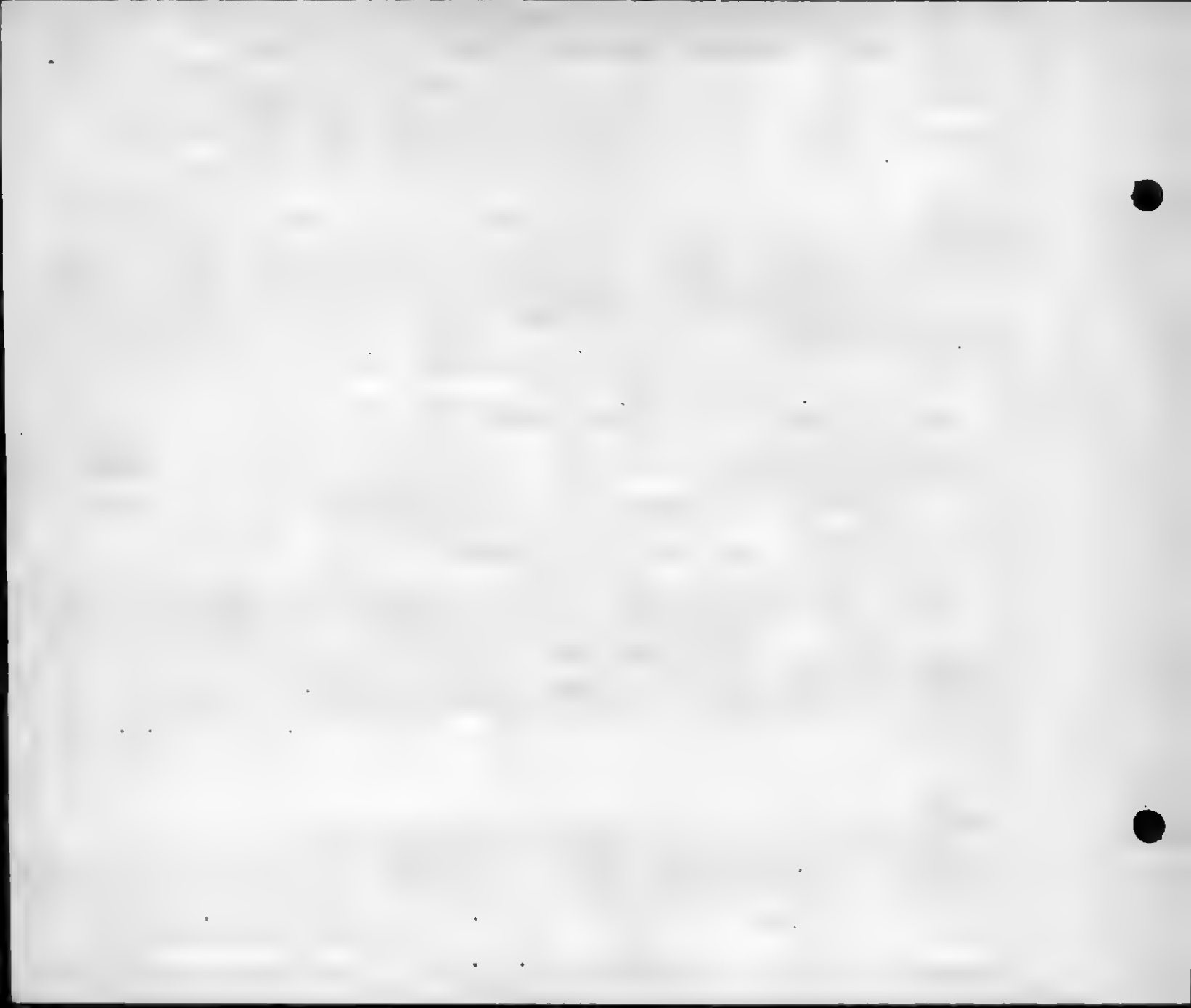
00187

Reg. Dist. No.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Anne Arundel</u> MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cape St. Clair</u>
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Swan Drive</u> | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>North Carolina</u> b. COUNTY _____
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Camp LeJeune</u>
d. STREET ADDRESS _____
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>RAYMOND</u> First <u>VINCENT</u> Middle <u>SHERMAN</u> Last | | | 4. DATE OF DEATH Month <u>January</u> Day <u>19</u> Year <u>1960</u> | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>June 1, 1935</u> | 9. AGE (In years last birthday) <u>24</u> yrs. | IF UNDER 1 YEAR
Months _____ Days _____ | IF UNDER 24 HRS.
Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done) <u>U.S. Marine</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Marine Corp.</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Baltimore, Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> |
| 13. FATHER'S NAME
<u>William G. Sherman, Sr.</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Rita Alfinito</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>1954-1960</u> | | 16. SOCIAL SECURITY NO.
<u>1954-1960</u> | | 17. INFORMANT Address <u>4120 Park Hgts. Md.</u>
<u>Mrs Rita Sherman, Mother Baltimore, Md.</u> | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
<div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY:
 IMMEDIATE CAUSE (a) <u>Poisoning by Carbon Monoxide</u>
 DUE TO _____
 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____
 DUE TO _____
 (c) _____ </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH
 <u>Sudden</u> </div> </div> | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>Connected hose to exhaust pipe of his car.</u> | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>11:30</u> <u>1-18</u> <u>1960</u> | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>car in yard</u> <u>Cape St. Clair, A.A. Md</u>
(County) _____ (State) _____ | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> | | | | | | |
| ACTUAL SIGNATURE
<u>Gustave H. Faubert, M.D.</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1/1/60</u> | | DATE SIGNED | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>1/22/60</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Cathedral Cemetery.</u> | | |
| 22d. LOCATION (City, town, or county) <u>Baltimore, Md.</u> (State) _____ | | | | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Ed Vernon Lemmon</u> | | | ADDRESS
<u>4611 Park Heights, Balto. Md.</u> | | | |
| 24a. REC'D BY REGISTRAR
<u>JAN 21 1960</u> | | | 24b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PB3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



1
FOR STATE
HEALTH DEPT.

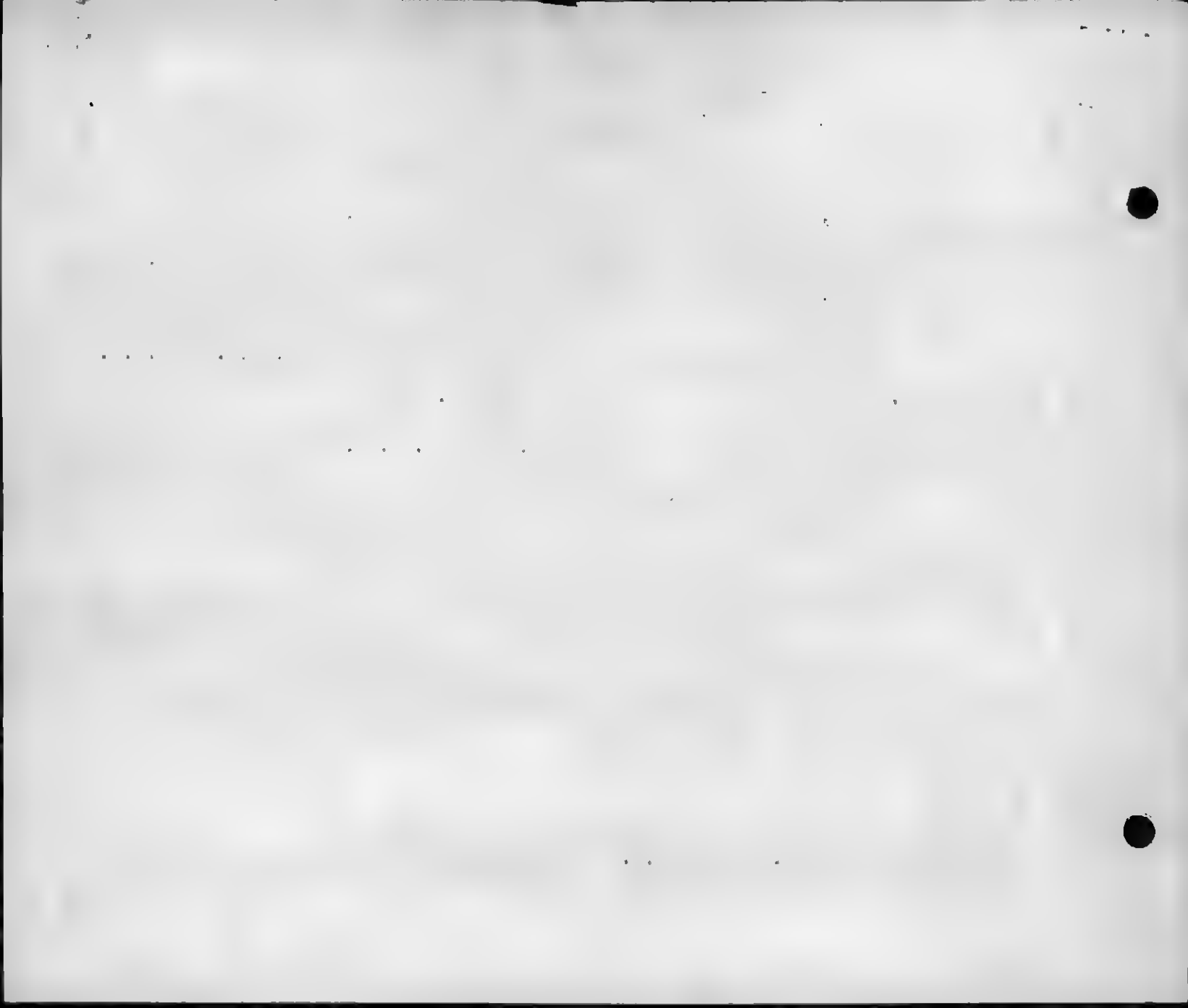
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any cause is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00188

| | | | |
|--|----------------------------------|--|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Anne Arundel</u> 0198 | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>Odenton</u> | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>Odenton</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>Box 438X, Route 1</u> | | d. STREET ADDRESS
<u>Box 438X, Route 1</u> | |
| 3. NAME OF DECEASED (Type or print)
<u>KATHLEEN ANNE SINGLETON</u> | | 4. DATE OF DEATH
Month <u>January</u> Day <u>10</u> Year <u>1960</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>12/9/59</u> |
| 9. AGE (In years last birthday)
<u>1</u> yrs. <u>1</u> Months <u>1</u> Days | | 10. IF UNDER 1 YEAR
Hours <u>1</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>None</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Fort Meade, Hospital, M.D.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Roscoe E. Singleton</u> | | 14. MOTHER'S MAIDEN NAME
<u>Dona M. Hood</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
<u>None</u> | | 16. SOCIAL SECURITY NO.
<u>None</u> | |
| 17. INFORMANT
<u>Mr. and Mrs. R. E. Singleton (parents)</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Interstitial pneumonitis</u>
<u>492X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>492X</u> DUE TO (c)
PART II. OTHER SIGNIF. CANT CONDITIONS CONTR BUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u> p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Russell S. Fisher</u> | | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>Russell S. Fisher, M.D.</u> | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| DATE SIGNED <u>1/11/60</u> | | Address (Street, city, town, or county) | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>1-11-1960</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>Glen Haven Cemetery</u> | | 22d. LOCATION (City, town, or country) (State)
<u>Glen Burnie - Md.</u> | |
| 23. FUNERAL DIRECTOR
<u>Robert P. Ware</u> | | ADDRESS
<u>Glen Burnie</u> | |
| 24a. REC'D BY REGISTRAR
<u>JAN 13 '60</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur L. Hines</u> | |



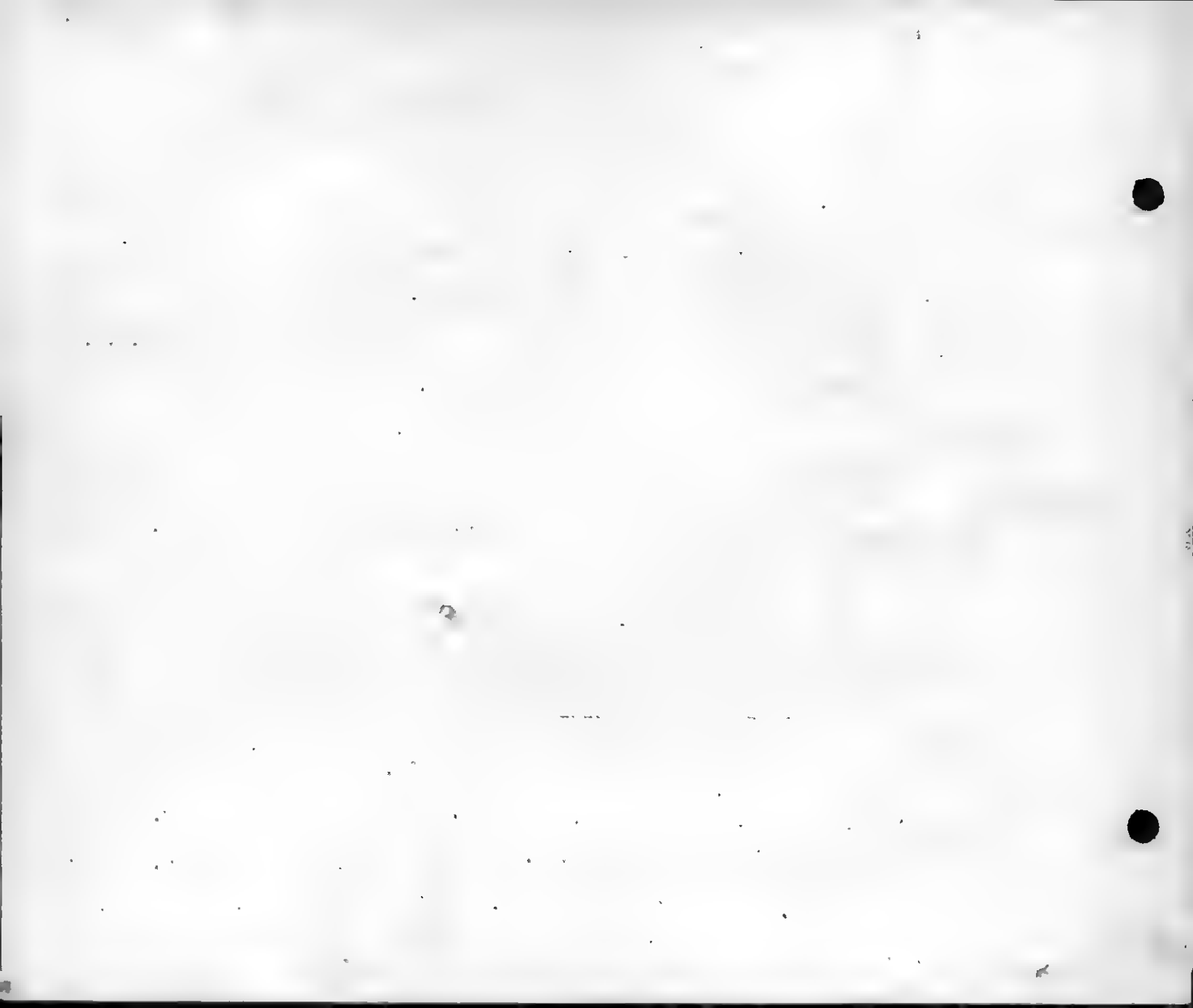
CERTIFICATE OF DEATH

Reg. Dist. No.

0197

| | | | | | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Anne Arundel | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Crownsville | | c. LENGTH OF STAY IN 1b
22 days | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE
Maryland | | b. COUNTY
Anne Arundel | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | d. STREET ADDRESS
505 Oakland Avenue | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First
Clara | | Middle
Johnson | | Last
Smith | | 4. DATE OF DEATH
Month
1 | | Day
18 | | Year
1960 | | 5. SEX
Female | | 6. COLOR OR RACE
Negro | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
May 3, 1889/ 1890 | | 9. AGE (In years lost birthday)
70 69rs. | | 10. IF UNDER 1 YEAR
Months
10 | | Days
69 | | Hours
18 | | Minutes
18 | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Cook - Maid | | 10b. KIND OF BUSINESS OR INDUSTRY
----- | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
Unknown | | 14. MOTHER'S MAIDEN NAME
Martha Lane | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO
240-16-5333 | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO
240-16-5333 | | INFORMANT
Chas. E. Smith | | Address
505 Oakland Ave | | 17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Uremia | | INTERVAL BETWEEN ONSET AND DEATH
Since Admission | | 18. CAUSE OF DEATH (b) Arteriosclerotic Hypertensive Cardiovascular Disease | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 18. CAUSE OF DEATH (c) Diabetes Mellitus | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):
Diabetes Mellitus | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
443X | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
----- | | 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 12/26 | | 20d. INJURY OCCURRED
While <input checked="" type="checkbox"/> Not while <input type="checkbox"/>
of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
----- | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 12/26 , 19 59 , to 1/18 , 19 60 , that I lost saw the deceased alive on 1/18 , 19 60 , and that death occurred at 1:00P M, from the causes and on the date stated above. | | ADDRESS (Street, city or town, state)
Crownsville State Hospital, Md. | | DATE SIGNED
1/18/60 | | ACTUAL SIGNATURE
Hildegard Heard Reissman | | M.D.
Crownsville State Hospital, Md. | | 1/18/60 | | PHYSICIAN'S NAME (Type)
Hildegard Heard Reissman, M. D. | | Crownsville State Hospital, Md. 1/18/60 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
1-21-1960 | | 22c. NAME OF CEMETERY OR CREMATORY
Brewer Hill | | 22d. LOCATION (City, town, or county) (State)
Annapolis Md | | 23. FUNERAL DIRECTOR'S SIGNATURE
William Reese | | ADDRESS
27 Anna. Rd. | | 24a. REC'D BY REGISTRAR
JAN 20 1960 | | 24b. REGISTRAR'S SIGNATURE
Charles S. Kenna | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH-18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00150

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>AA</u> <u>DO</u> <u>0136</u>
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>AA</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | | c. LENGTH OF STAY IN lb <u>DOA</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. Anne Arundel General</u> | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x Glen Burnie</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>WALTER</u> Middle <u>H.</u> Last <u>SMITH JR.</u> | | f. STREET ADDRESS <u>15 Normandy Drive</u> | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>1-15-21</u> | |
| 9. AGE (In years last birthday) <u>39</u> yrs. | | 10. IF UNDER 1 YEAR Months <u>27</u> Days <u>3</u> Hours <u>19</u> Min. <u>60</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Marine Mechanic</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Stickle Marine</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Walter H. Smith, Sr.</u> | | 14. MOTHER'S MAIDEN NAME <u>Evelyn A. Kennedy</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> | | 16. SOCIAL SECURITY NO. <u>215-28-6101</u> | |
| 17. INFORMANT <u>Ms. Dorothy L. Smith</u> | | Address <u>Same as #2</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Head Injury</u>
823x DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>823x</u>
DUE TO (c) <u>Subdural</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERNAL BETWEEN ONSET AND DEATH</u> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident - ran into</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>1-3 1960</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>RT 12</u> | | 20f. (City or town) <u>AA</u> (County) <u>MD</u> (State) <u>MD</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <u>E. Linhardt</u> | | DATE SIGNED <u>1/3/60</u> | |
| F. LINHARDT M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| NAME (Type) <u>E. Linhardt</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>7 Jan. '60</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u> | | 22d. LOCATION (City, town, or county) <u>Glen Burnie, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>R. J. Sington</u> | | ADDRESS <u>Glen Burnie, Md.</u> | |
| 24a. REC'D BY REGISTRAR <u>7 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Walter L. Sington</u> | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 00191

| | | | |
|---|---------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>A.A. Co</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>Alto</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> | | c. LENGTH OF STAY IN 1b <u>1</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Brunel General</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Wm.</u> Middle <u>Everett</u> Last <u>Smith</u> | | 4. DATE OF DEATH
Month <u>1</u> Day <u>3</u> Year <u>1960</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12/8/33</u> |
| 9. AGE (In years last birthday) <u>26</u> yrs. | | IF UNDER 1 YEAR
Months <u>2</u> Days <u>6</u> | IF UNDER 24 HRS.
Hours <u>1</u> Min. <u>30</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>John Trophy</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Walter H. Smith Sr.</u> | | 14. MOTHER'S MAIDEN NAME <u>Evelyn A. Kennedy</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>Korean</u> | | 16. SOCIAL SECURITY NO. <u>213-30-6128</u> | |
| 17. INFORMANT <u>Mrs. Arden J. Smith</u> | | Address <u>Same As #2</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Head Injury -</u>
<u>223x</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (b) _____
(c), stating the underlying cause lost. DUE TO _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____
INTERVAL BETWEEN ONSET AND DEATH <u>3+ hours</u> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto Accident - r.r. into pile</u> | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>1.3</u> a.m. <u>1960</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <u>at work</u> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route #2</u> | | 20f. (City or town) <u>AA Co. MD</u> (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <u>E. Linhardt</u> | | DATE SIGNED <u>1.3.60.</u> | |
| EXAMINER'S NAME (Type) <u>E. Linhardt</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>7 Jan. '60</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven</u> | | 22d. LOCATION (City, town, or county) <u>Glen Burnie Md</u> (State) | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>R. J. Singleton</u> | | ADDRESS <u>Glen Burnie, Md.</u> | |
| 24a. REC'D BY REGISTRAR <u>JAN 7 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u> | |



0199

CERTIFICATE OF DEATH

Reg. Dist. No.

00192

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>aa</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>md</u> b. COUNTY <u>aa</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Mayo</u> | | c. LENGTH OF STAY IN 1b
<u>Mayo</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address)
<u>Holly Hill Harbor</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>William Raleigh Smith</u> | | 4. DATE OF DEATH
Month <u>1</u> - Day <u>10</u> Year <u>1960</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>July 27th 1897</u> |
| 9. AGE (In years last birthday)
<u>62</u> yrs | | 10. IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 11. USUAL OCCUPATION (Give kind of work done during most of work ng life, even if retired)
<u>Waterman</u> | | 12. KIND OF BUSINESS OR INDUSTRY
<u>Crabs & Oysters</u> | |
| 13. BIRTHPLACE (State or foreign country)
<u>Mayo Md</u> | | 14. CITIZEN OF WHAT COUNTRY?
<u>U. S. A</u> | |
| 15. FATHER'S NAME
<u>James Edward Smith</u> | | 16. MOTHER'S MAIDEN NAME
<u>Harriet Ann Lee</u> | |
| 17. WAS DECEASED EVER IN U. S. ARMED FORCES?
(If yes, give war or dates of service) | | 18. SOCIAL SECURITY NO.
<u> </u> | |
| 19. INFORMANT
<u>Edward Smith</u> | | 20. ADDRESS
<u>389 Annapolis St Annapolis Md</u> | |
| 21. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>
DUE TO (b) <u>Intermittent Heart Disease</u>
DUE TO (c) <u> </u> | | | |
| INTERVAL BETWEEN ONSET AND DEATH
<u>2 days</u>
<u>1 day</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | |
| 22. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 23a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 23b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 24a. TIME OF INJURY Month, Day, Year
Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u> | | 24b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 25a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 25b. (City or town) (County) (State) | |
| 26. I certify that I attended the deceased from <u>Jan 1 - 9 - 1960</u> to <u>1 - 10 - 1960</u> , that I last saw the deceased alive on <u>1 - 9 - 1960</u> , and that death occurred at <u>9:15</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>James R. Martin</u> | | DATE SIGNED <u>1-11-60</u> | |
| PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u> | | ADDRESS (Street, city or town, state) <u>6 SHAW ST. ANNAPOLIS, MD.</u> | |
| 27a. BURIAL, CREMATION, REMOVAL (Specify) | | 27b. DATE THEREOF | |
| <u>Burial</u> | | <u>1-13-60</u> | |
| 28a. NAME OF CEMETERY OR CREMATORY | | 28b. LOCATION (City, town, or county) (State) | |
| <u>Mayo Memorial Cent</u> | | <u>Mayo Md</u> | |
| 29. FUNERAL DIRECTOR'S SIGNATURE
<u>John M. Saylor Sons</u> | | 29b. REGISTRAR'S SIGNATURE
<u>Arthur S. Harris</u> | |
| DATE <u>JAN 14 '60</u> | | DATE <u>JAN 14 '60</u> | |



0199 CERTIFICATE OF DEATH

00193

Reg. Dist. No.

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <i>aa</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE <i>md</i> b. COUNTY <i>aa</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Green</i> | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Sylvan Shores</i> | | d. STREET ADDRESS <i>Sylvan Shores</i> | |
| 3. NAME OF DECEASED (Type or print) <i>Bettie M. Salman</i> | | 4. DATE OF DEATH
Month <i>1</i> - Day <i>28</i> Year <i>1960</i> | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Feb 21 1909</i> |
| 9. AGE (In years lost birthday) <i>50</i> yrs | | 10. IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i> | |
| 11. BIRTH PLACE (State or foreign country) <i>Ma.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i> | |
| 13. FATHER'S NAME <i>James H. Montague</i> | | 14. MOTHER'S MAIDEN NAME <i>Ibra Hoggarty</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO <i>-</i> | |
| 17. INFORMANT <i>John J. Salman</i> | | Address <i>(2)</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Metastatic carcinoma of left breast</i>
<i>170X</i> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH <i>7 yrs.</i> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY
Hour a. m. p. m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <i>1955</i> , 19 <i>Jun 28</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>Jun 24</i> , 19 <i>60</i> , and that death occurred at <i>4 p</i> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>John L. Haden</i> | | ADDRESS (Street, city or town, state) <i>121 Cathedral</i> DATE SIGNED <i>1/29/60</i> | |
| PHYSICIAN'S NAME (Type) <i>Annapolis Md</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town or county) (State) |
| <i>Burial</i> | <i>1-30-60</i> | <i>Glen Haven Cem</i> | <i>Glen Burnie Md</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i> | | ADDRESS <i>Annapolis Md</i> | |
| 24a. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE | |
| DATE <i>FEB 2 '60</i> | | <i>Arthur L. Kraus</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 11 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1 7 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0200

CERTIFICATE OF DEATH

00194

Reg. Dist. No.

| | | | | | | | |
|--|------------------------------|---|---------------------------------------|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Anne Arundel</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>A A</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Pasadena</u> | | c. LENGTH OF STAY IN 1b
<u>1 yr</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>X3800 E Potomac Rd Zone 29</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>442 Vinodown Road</u> | | | | d. STREET ADDRESS
<u>Baltimore Md</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Florence Elizabeth Taylor</u> | | | | 4. DATE OF DEATH
Month <u>1</u> Day <u>23</u> Year <u>1960</u> | | | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Dec 5 1877</u> | | 9. AGE (In years last birthday)
<u>82</u> yrs | IF UNDER 1 YEAR
Months Days Hours Min | IF UNDER 24 HRS
Months Days Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Home</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Balto. Md</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>John Taylor</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Janie (Unknown)</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>None</u> | | 17. INFORMANT
<u>Mrs. Virginia Newcomer</u> | | Address <u>3805 Potomac Rd Balto. #29, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Heart Disease</u>
<u>422.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Dissecting aortic C.V. disease</u>
DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____
INTERVAL BETWEEN ONSET AND DEATH _____ | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>1-21-60</u> to <u>1-23-60</u> , that I last saw the deceased alive on <u>1-21-60</u> , 19 <u>60</u> , and that death occurred at <u>4:35</u> M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) _____ DATE SIGNED _____
ACTUAL SIGNATURE <u>Robert R. Holmes</u> M.D. <u>Severna Park 1-23-60</u>
PHYSICIAN'S NAME (Type) <u>Robert R. Holmes</u> M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>27 Jan '60</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Glen Haven Cem.</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Glen Burnie Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>H. V. Singleton</u> | | | | ADDRESS
<u>Glen Burnie, Md.</u> | | 24a. REC'D BY REGISTRAR
DATE <u>JAN 26 '60</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Evans</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relayed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0201

CERTIFICATE OF DEATH

Reg. Dist. No. 00195

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
b. COUNTY St. Mary's | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Crownsville | | | | c. LENGTH OF STAY IN 1b
7 years 9mo. 3 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
Crownsville State Hospital | | | | d. STREET ADDRESS
Unknown | | | |
| 3. NAME OF DECEASED (Type or print)
First William Middle Alexander Last Thompson | | | | 4. DATE OF DEATH
Month 1 Day 25 Year 1960 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
Negro | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
3/5/1896 | |
| 9. AGE (In years lost birthday)
63 yrs | | 10. IF UNDER 1 YEAR
Months 63 Days 0 Hours 0 Min 0 | | 11. IF UNDER 24 HRS
Hours 0 Min 0 Sec 0 | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Cook | | | | 10b. KIND OF BUSINESS OR INDUSTRY
----- | | | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
William Thompson | | | | 14. MOTHER'S MAIDEN NAME
Martha Eyglen | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
Yes World War I | | | | 16. SOCIAL SECURITY NO
Unknown | | 17. INFORMANT
Hospital Records | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion
420.6 DUE TO
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Hypertensive Cardiovascular Disease
DUE TO (c) ----- | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ----- | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
----- | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour 19 o. m. ----- p. m. ----- | | 20d. INJURY OCCURRED
While <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, parlor street office bldg etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 4/22 , 19 52 , to 1/25 , 19 60 , that I last saw the deceased alive on 1/25 , 19 60 , and that death occurred at 6:50 P. M. , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) Crownsville State Hospital, Md. DATE SIGNED 1/26/60 | | | | | | | |
| ACTUAL SIGNATURE Hildegard Heard Reissman, M. D. | | | | DATE SIGNED 1/26/60 | | | |
| PHYSICIAN'S NAME (Type) Hildegard Heard Reissman, M. D. | | | | ADDRESS Crownsville State Hospital, Md. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
1-30-60 | | 22c. NAME OF CEMETERY OR CREMATORY
St Francis Xavier | | 22d. LOCATION (City, town, or county) (State)
Compton Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
W. Clarke Mattingley | | | | ADDRESS
Leonardtown, Md. | | 24a. REC'D BY REGISTRAR
DATE FEB 1 '60 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur L. Hanna | | | | | | | |

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

Reg. Dist. No.

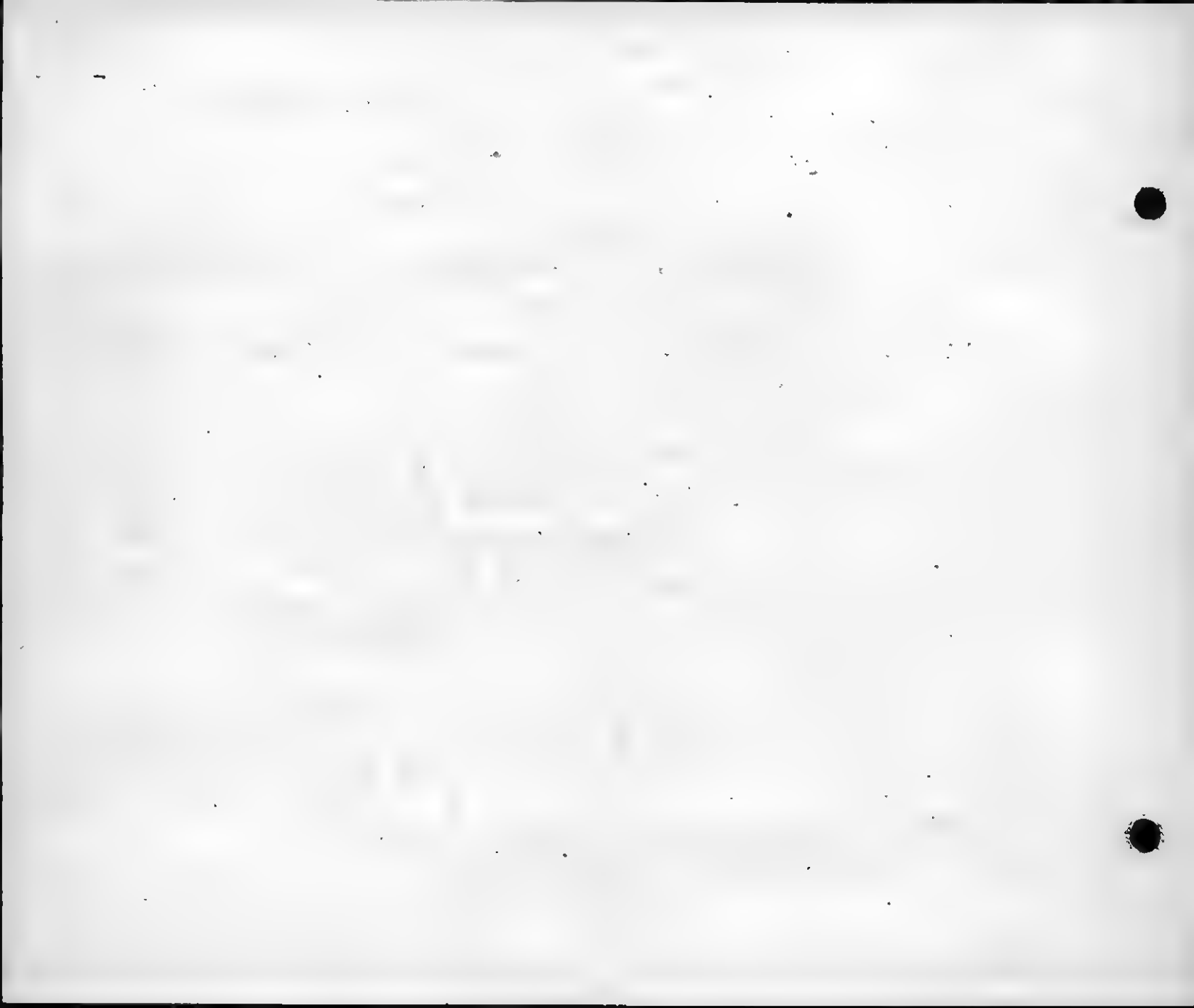
00196

0202

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Prince Georges Co</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Prince Georges Co</u> b. COUNTY <u>Prince Georges Co</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stenturme</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stenturme</u> | |
| c. LENGTH OF STAY IN 1b <u>24 hrs</u> | | d. STREET ADDRESS <u>511 Hamlen Rd.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>511 Hamlen Rd.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF <u>Turner</u>
(Type or print) First <u>Milton J.</u> Middle <u>Turner</u> Last <u>Turner</u> | | 4. DATE OF DEATH <u>Jan 3 - 1960</u>
Month <u>Jan</u> Day <u>3</u> Year <u>1960</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>19 Feb. 1872</u> |
| 10a. USJAK OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Turner (Retired)</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Prince Georges Co Md</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>James W. Turner</u> | | 14. MOTHER'S MAIDEN NAME <u>Catherine C. (Unknown)</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>332x</u> DUE TO <u>Acute Cardiac Failure</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Later Infection</u> DUE TO <u>Cerebral Infarct</u>
(c) <u>Chronic Infection</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Infection</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>None</u> | |
| 20c. TIME OF INJURY Month <u>Jan</u> Day <u>3</u> Year <u>1960</u>
Hour <u>0</u> p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | | 20f. City or town <u>Stenturme</u> (County) <u>Prince Georges</u> (State) <u>Md</u> | |
| 21. I certify that I attended the deceased from <u>Nov 11 - 59</u> to <u>Jan 3 - 1960</u> what I last saw the deceased alive on <u>Jan 2 - 1960</u> , and that death occurred at <u>Stenturme</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Joseph Lipsky</u> | | DATE SIGNED <u>1/3/60</u> | |
| PHYSICIAN'S NAME (Type) <u>JOSEPH LIPSKY</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>6 January 1960</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>St. Stephens Ch. Cem.</u> | 22d. LOCATION (City, town, or county) <u>Millersville, Md.</u> (State) <u>Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur L. Hanna</u> | | 24a. REC'D BY REGISTRAR <u>Arthur L. Hanna</u> | |
| ADDRESS <u>Glen Burnie Md.</u> | | DATE <u>JAN 7 '60</u> | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



0135 CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY ANNE ARUNDEL MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY A.A.C. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ANNAPOLIS | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 909 WELLS AVE | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) EDWARD T. TYDINGS | | 4. DATE OF DEATH
Month 1 Day 21 Year 1960 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5-18-1884 |
| 9. AGE (In years last birthday) 75 yrs | | IF UNDER 1 YEAR
Months 1 Days 21 Hours 19 Min. | IF UNDER 24 HRS.
Months 1 Days 21 Hours 19 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STREET DEPT. City Gov't. | | 10b. KIND OF BUSINESS OR INDUSTRY MARYLAND | |
| 11. BIRTHPLACE (State or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME GEORGE R. TYDINGS | | 14. MOTHER'S MAIDEN NAME MARY R. KING | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — | | 16. SOCIAL SECURITY NO. 215-24-9803 | |
| 17. INFORMANT MRS. JONES #2 | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CEREBRAL ARTERIO SCLEROSIS
DUE TO
(c) 5 YEARS | | INTERVAL BETWEEN ONSET AND DEATH 5 YEARS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) MAINTENANCE | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. 19 p. m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 12-15, 1959 to 1-21, 1960 , that I last saw the deceased alive on 1-21, 1960 , and that death occurred at 4 P M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Edward T. Tydings | | DATE SIGNED 1/22/60 | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) |
| BURIAL | 1-25-60 | CEDAR BLUFF | ANNAPOLIS MD. |
| 23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor Sons | | 24a. REC'D BY REGISTRAR ANNE ARUNDEL Co. | 24b. REGISTRAR'S SIGNATURE Arthur E. Howard |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

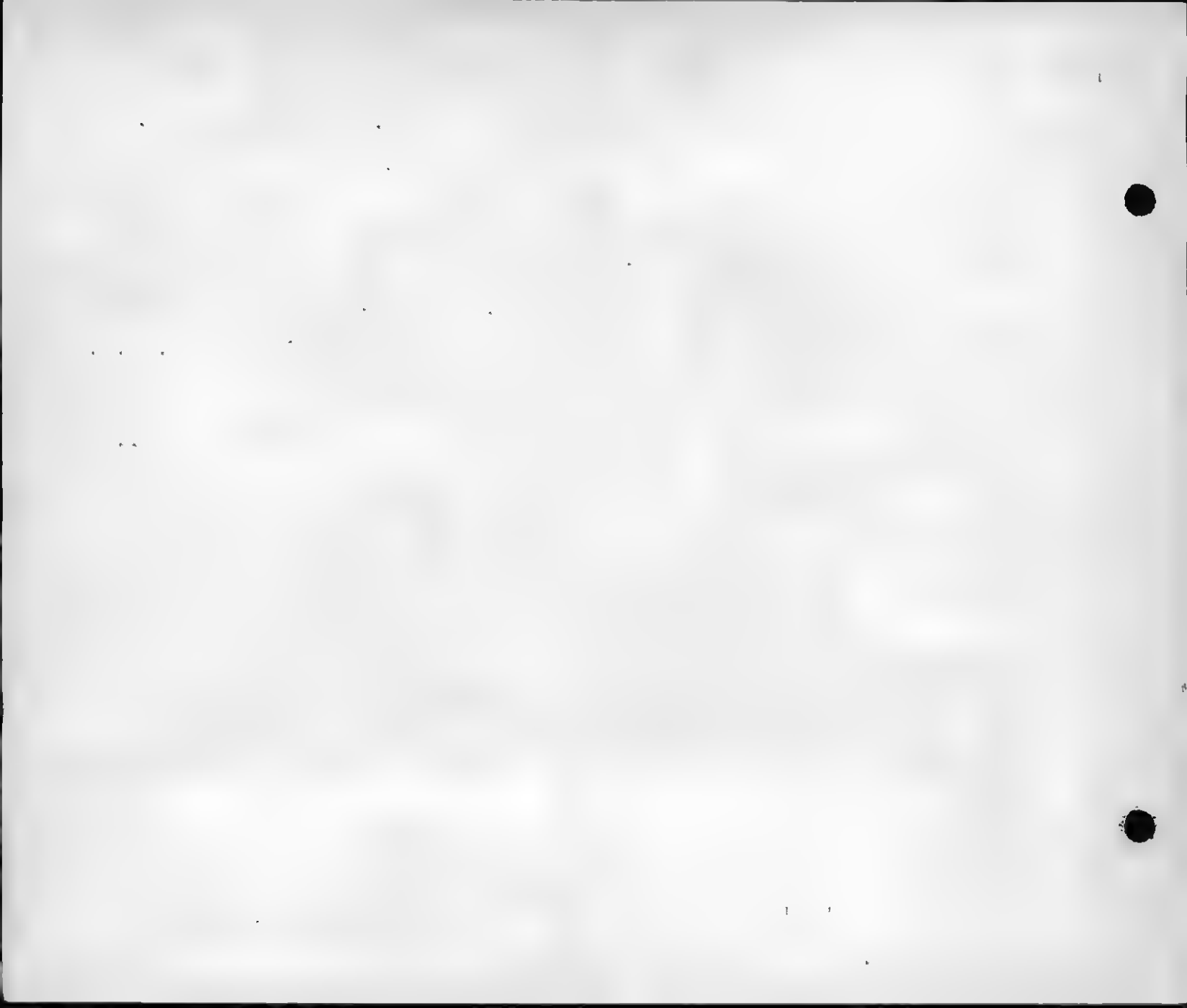
00198

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Ad Co.</u> 0139 | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u> ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Baltimore</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>800 Ave. Arundel Gen.</u> | | d. STREET ADDRESS
<u>4130 Wilkens Avenue</u> | |
| 3. NAME OF DECEASED
(Type or print)
First <u>Gertrude</u> Middle <u>L.</u> Last <u>WALKER</u> | | 4. DATE OF DEATH
Month <u>1</u> Day <u>27</u> Year <u>1960</u> | |
| 5. SEX
<u>F.</u> | 6. COLOR OR RACE
<u>W.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Oct. 20, 1884</u> |
| 9. AGE (In years last birthday)
<u>75</u> yrs | | IF UNDER 1 YEAR
Months _____ Days _____ | IF UNDER 24 HRS
Hours _____ Min. _____ |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
<u>Springfield, Illinois</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U. S. A.</u> | |
| 13. FATHER'S NAME
<u>Theodore Hanft</u> | | 14. MOTHER'S MAIDEN NAME
<u>Louisa Bender</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
<u>no</u> | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
<u>Dorothy Frantz</u> | | Address
<u>4130 Wilkens Ave, #29</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
<div style="display: flex; justify-content: space-between;"> <div> <p>PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Disease</u>
<u>434.4</u> DUE TO</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</p> </div> <div> <p>(b) _____ DUE TO</p> <p>(c) _____ DUE TO</p> </div> <div> <p>INTERVAL BETWEEN ONSET AND DEATH
<u>1 hour</u></p> </div> </div> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.) | |
| 20c. TIME OF INJURY
Month. Day. Year
Hour <u>19</u> o. m. _____ p. m. _____ | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>[Signature]</u> | | DATE SIGNED <u>1.27.60.</u> | |
| EXAMINER'S NAME (Type) <u>E. Linhardt</u> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL CREMATION REMOVAL (Specify)
<u>Burial</u> | 22b. DATE THEREOF
<u>1'30'60</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>Loudon Park Cemetery</u> | 22d. LOCATION (City, town, or county) (State)
<u>Baltimore, Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Howard H. Hubbard</u> | | 24a. REC'D BY REGISTRAR
DATE <u>JAN 29 '60</u> | |
| ADDRESS
<u>4107 Wilkens Ave.</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur L. Lewis</u> | |



0203

CERTIFICATE OF DEATH

Reg. Dist. No.

00193

| | | | |
|--|--|--|--|
| 1 PLACE OF DEATH
a. COUNTY <u>CROWN</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CROWNSVILLE</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CRISFIELD</u> | |
| c. LENGTH OF STAY IN 1b <u>3/22/49</u> | | d. STREET ADDRESS <u>CRISFIELD</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PROVINCIAL STATE HOSPITAL</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>S.</u> Last <u>WATERS</u> | | 4. DATE OF DEATH Month <u>1</u> Day <u>16</u> Year <u>1960</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>C</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>UNKNOWN TO US</u> |
| 9. AGE (In years lost birthday) <u>30 7</u> yrs | | IF UNDER 1 YEAR IF UNDER 24 HRS | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>NOT LISTED</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>USA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>WILLIAM T. WATERS</u> | | 14. MOTHER'S MAIDEN NAME <u>NOT LISTED</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>NONE</u> | |
| 17. INFORMANT <u>HOSPITAL RECORDS</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>KACHEXIA</u>
DUE TO <u>GENERAL PARESIS</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>CHRONIC BRAIN SYNDROME ASSOCIATED WITH CIN SYPHILIS</u>
DUE TO <u>CHRONIC BRAIN SYNDROME ASSOCIATED WITH CIN SYPHILIS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH <u>2 WEEKS</u>
<u>Known since admission 1949</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a m p m <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>7/22</u> , 19 <u>49</u> , to <u>1/16</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1/16/60</u> , 19 <u>60</u> , and that death occurred at <u>2</u> P.M., from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>CROWNSVILLE STATE HOSPITAL</u> DATE SIGNED <u>CRISFIELD, MD.</u> | | | |
| ACTUAL SIGNATURE <u>L. BENEDICT M.D.</u> | | M.D. <u>CRISFIELD, MD.</u> | |
| PHYSICIAN'S NAME (Type) <u>L. BENEDICT M.D.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>JAN. 19, 1960</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>LAWSONIA CEMETERY</u> | 22d. LOCATION (City, town, or county) (State) <u>CRISFIELD MD.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>BRADSHAW & SONS</u> | | ADDRESS <u>CRISFIELD, MD.</u> | |
| 24a. REC'D BY REGISTRAR DATE <u>JAN 20 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>William L. Kenna</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

00200
 27

0204

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Anne Arundel</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Fort George G Meade</u> | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>U.S. Army Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>KATHI</u> Middle <u>DAWN</u> Last <u>WATKINS</u> | | | | 4. DATE OF DEATH
Month <u>January</u> Day <u>8</u> Year <u>1960</u> | | | |
| 5. SEX
<u>Female</u> | | 6. COLOR OR RACE
<u>Cau</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>10 October 58</u> | |
| 9. AGE (In years last birthday)
<u>1</u> yrs. | | IF UNDER 1 YEAR
Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. | | IF UNDER 24 HRS
Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>-</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>-</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | | | | | | |
| 13. FATHER'S NAME
<u>Fred Warren Watkins</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Anna Dawn Wallace</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>-</u> | | | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service)
<u>-</u> | | | |
| 17. INFORMANT
(F) Fred W Watkins | | | | Address
Ft Geo G Meade, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory failure</u>
<u>331X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Central Nervous system, hemorrhage</u>
DUE TO (c) <u>Febrile convulsion</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>Unknown</u>
<u>Approx 32 hrs</u>
<u>Approx 32 hrs</u> |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>o. m.</u> <u>19</u> p. m. | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | (County) | | (State) | |
| 21. I certify that I attended the deceased from <u>7 Jan</u> , 1960, to <u>8 Jan</u> , 1960, that I last saw the deceased alive on <u>8 Jan</u> , 1960, and that death occurred at <u>10:55 PM</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Roger C. Meyer, Capt., M.D.</u> | | | | ADDRESS (Street, city or town, state)
<u>U.S. Army Hospital Ft Geo G Meade, Md</u> | | | |
| PHYSICIAN'S NAME (Type)
<u>Roger C Meyer, Capt., M.D.</u> | | | | DATE SIGNED
<u>8 Jan 60</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 22b. DATE THEREOF
<u>1-13-60</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Arlington National Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Arlington, Va</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Wm. Cook, Inc., 1217 St. Paul Street</u> | | | | ADDRESS
<u>1217 St. Paul Street</u> | | 24a. REC'D BY REGISTRAR
<u>JAN 12 '60</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kross</u> | | | |

MEDICAL CERTIFICATION



0205

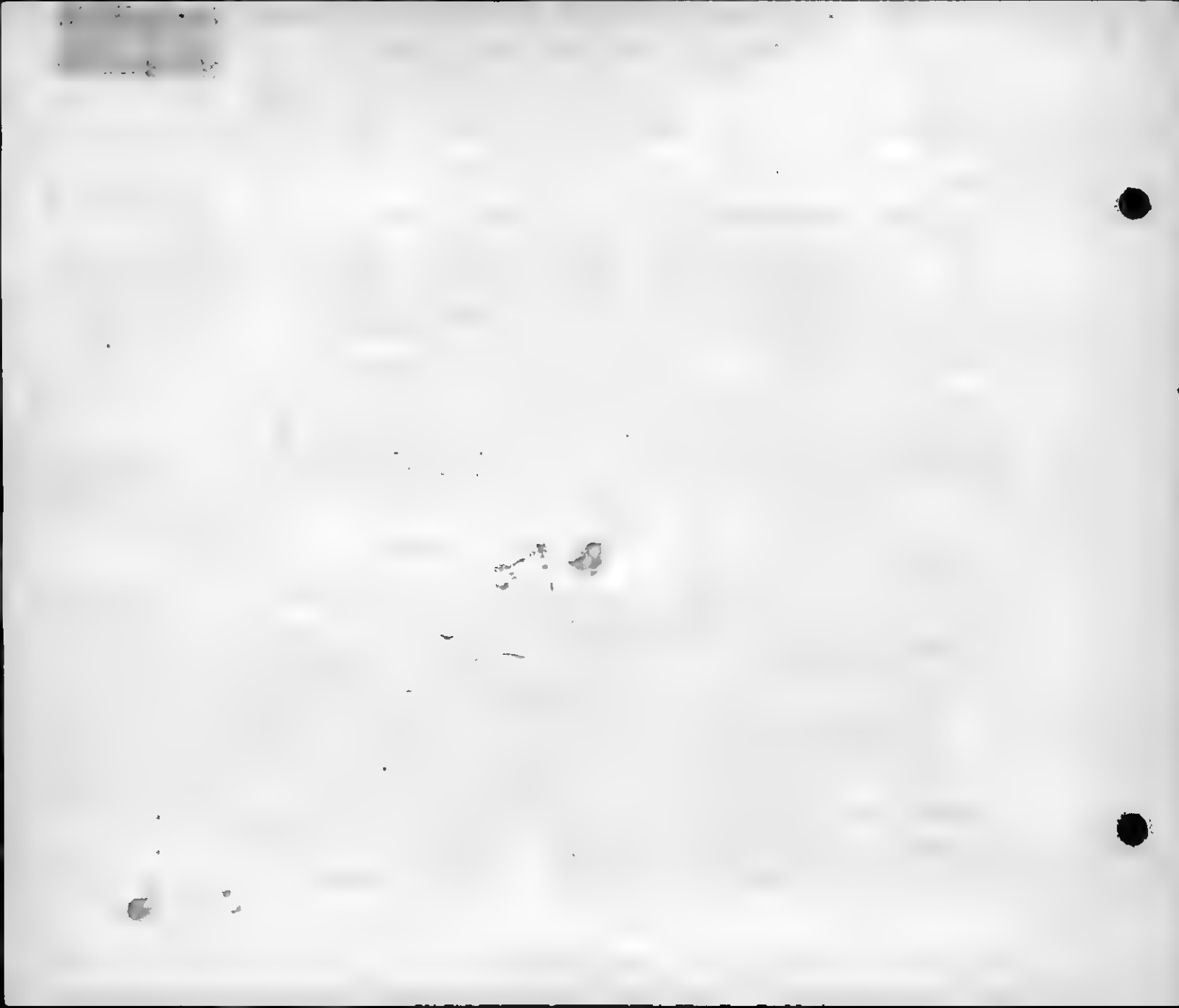
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>MARYLAND</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Crownsville</u> | | | | c. LENGTH OF STAY IN 1b
<u>1 Y. 29 Days</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Crownsville State Hospital</u> | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Nathan</u> Middle <u>White</u> Last <u>White</u> | | | | 4. DATE OF DEATH
Month <u>1</u> Day <u>11</u> Year <u>1960</u> | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>Negro</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>1/31/1890</u> | |
| 9. AGE (In years last birthday)
<u>69</u> | | 10. IF UNDER 1 YEAR
Months <u>6</u> Days <u>11</u> Hours <u>11</u> Min. <u>3</u> | | 11. IF UNDER 24 HRS.
Months <u>6</u> Days <u>11</u> Hours <u>11</u> Min. <u>3</u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Laborer</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Unknown</u> | | | |
| 11. BIRTHPLACE (State or foreign country)
<u>Unknown</u> | | | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | |
| 13. FATHER'S NAME
<u>Unknown</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Ida Pollard White</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]
<u>Unknown</u> | | | | 16. SOCIAL SECURITY NO.
<u>136-13-080</u> | | | |
| 17. INFORMANT
<u>Hospital Records</u> | | | | Address | | | |
| 18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)}
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Uremia</u>
<u>286.5</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Malnutrition & Dehydration, Anorexia</u>
DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>(-10) 3</u> |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Cerebral Arteriosclerosis</u> | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>- - - - -</u> | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. <u>19</u> p. m. <u>-</u> | | | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>- - - - -</u> | |
| 20f. (City or town)
<u>- - - - -</u> | | | | 20g. (County)
<u>- - - - -</u> | | 20h. (State)
<u>- - - - -</u> | |
| 21. I certify that I attended the deceased from <u>12/12</u> , 19 <u>59</u> , to <u>1/11</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1/11</u> , 19 <u>60</u> , and that death occurred at <u>7:25</u> A.M., from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>Crownsville State Hospital, Md.</u> DATE SIGNED <u>1/12/60</u> | | | | | | | |
| ACTUAL SIGNATURE <u>Hilgard Heard Reiser</u> M.D. <u>Crownsville State Hospital, Md.</u> <u>1/12/60</u> | | | | | | | |
| PHYSICIAN'S NAME (Type) <u>Hilgard Heard Reiser, M.D.</u> <u>Crownsville State Hospital, Md.</u> <u>1/12/60</u> | | | | | | | |
| 22a. (BURIAL) CREMATION, REMOVAL (Specify)
<u>1-15-59</u> | | 22b. DATE THEREOF
<u>1-15-59</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>St. Auburn</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Baltimore Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Halstead Branch</u> | | | | 24a. REC'D BY REGISTRAR
<u>1/15/60</u> | | 24b. REGISTRAR'S SIGNATURE
<u>William L. Thomas</u> | |

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



Reg. Dist. No. 00202

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be released by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>W. CO.</u> <u>MARYLAND</u> | | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE <u>MD.</u> b. COUNTY <u>AT. CO.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bristol</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bristol, Md.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print)
First <u>Gus</u> Middle <u>Edward</u> Last <u>Wilkerson</u> | | 4. DATE OF DEATH
Month <u>1</u> Day <u>30</u> Year <u>1960</u> | |
| 5. SEX
<u>M.</u> | 6. COLOR OR RACE
<u>C</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>May 10,</u> |
| 9. AGE (In years last birthday)
<u>47</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>hatter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Thomas Wilkerson</u> | | 14. MOTHER'S MAIDEN NAME
<u>Priscilla Wilkerson</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u> </u> | | 16. SOCIAL SECURITY NO.
<u>177-17-1111</u> | |
| 17. INFORMANT
<u>177-17-1111</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>
<u>4/20/60</u> DUE TO <u>coronary artery disease</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u>
(c) <u> </u> DUE TO <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour <u> </u> a. m. <u> </u> p. m. <u> </u> Month <u> </u> Day <u> </u> Year <u> </u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u> </u> 19 <u>54</u> , to <u>Nov 21</u> , 19 <u>60</u> ; that I last saw the deceased alive on <u> </u> , 19 <u> </u> , and that death occurred at <u>8 P.</u> M., from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u>1-31-60</u>
ACTUAL SIGNATURE <u>Emil H. Wilkin</u> M.D. <u> </u>
PHYSICIAN'S NAME (Type) <u>acting coroner</u> | | | |
| 22a. BURIAL (CREMATION, REMOVAL) (Specify)
<u>2-2-60</u> | | 22b. DATE THEREOF | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>Carrion</u> | | 22d. LOCATION (City, town, or county) (State)
<u>AT. CO.</u> <u>MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u> </u> | | 24a. REC'D BY REGISTRAR
<u> </u> | |
| 24b. REGISTRAR'S SIGNATURE
<u> </u> | | 24c. REGISTRAR'S SIGNATURE
<u> </u> | |



1

0140

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

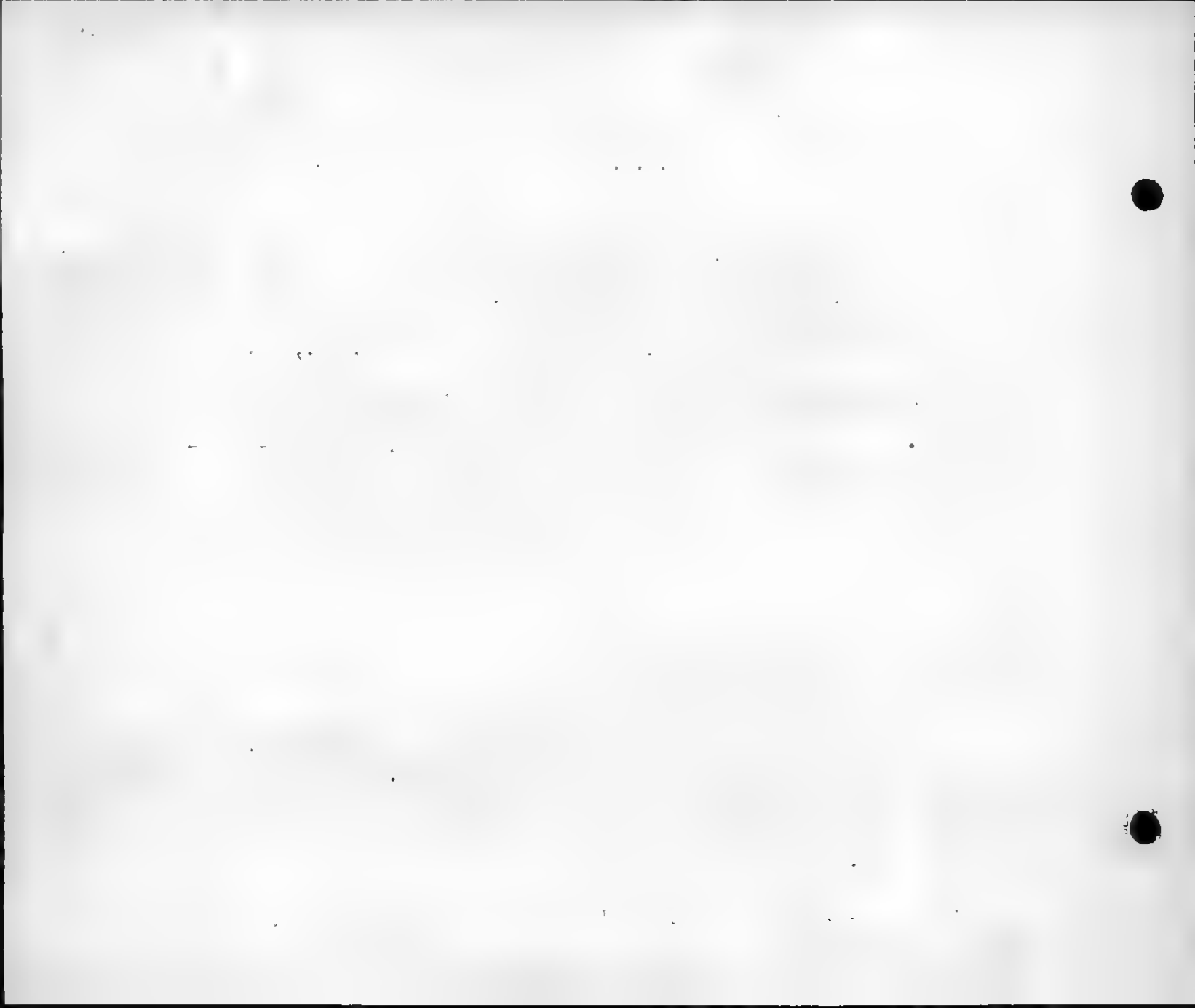
Reg. Dist. No.

00293

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Annapolis</u> | | | | c. LENGTH OF STAY IN 1b
<u>D.O.A.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Anne Arundel General Hospital</u> | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Woodland Beach</u> | | | |
| | | | | f. STREET ADDRESS
<u>Edgewater</u> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>JOSEPH</u> Middle <u>P</u> Last <u>WILKINSON</u> | | | | 4. DATE OF DEATH
Month <u>January</u> Day <u>6</u> Year <u>1960</u> | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Oct. 9, 1914</u> | |
| 9. AGE (In years last birthday)
<u>45</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Carpenter</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Prince Geo. Col., Md.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>William Philmore Wilkinson</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Mary Stamp</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>no</u> | | | | 16. SOCIAL SECURITY NO.
<u>220 07 5005</u> | | | |
| | | | | 17. INFORMANT
<u>Mrs Jeannette A. Wilkinson- Wife- same as # 2</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary occlusion</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery disease</u>
DUE TO
(c) _____ | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>3 1/4 hrs</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. _____ p. m. _____ 19 _____ | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) _____ (County) _____ (State) _____ | | | |
| 21. I certify that I attended the deceased from <u>January 6, 1960</u> to <u>January 6, 1960</u> , that I last saw the deceased alive on <u>Jan 6, 1960</u> , and that death occurred at <u>4:35 PM</u> , from the causes and on the date stated above.
Dead on arrival at hospital in ambulance | | | | | | | |
| ACTUAL SIGNATURE <u>S. Borssuck</u> | | | | M.D. <u>Amos S. Borssuck</u> DATE SIGNED <u>1/8/60</u> | | | |
| PHYSICIAN'S NAME (Type) <u>S. Borssuck</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>1-9-60</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>St. Mary's Cemetery</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Annapolis, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Hopping Funeral Home</u> | | | | 24a. REC'D BY REGISTRAR
<u>JAN 11 '60</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Charles S. Knepp</u> | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be returned to the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



0207

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|-----------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Ad. County</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Ad. County</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Skidmore</u> | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Hattie Williams</u> | | 4. DATE OF DEATH Month <u>1</u> Day <u>5</u> Year <u>1960</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Col</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>6-12-1879</u> |
| 9. AGE (In years last birthday) <u>80</u> yrs | | 10. IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Unknown</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>Unknown</u> | |
| 17. INFORMANT <u>Hilda Williams</u> | | Address <u>Skidmore, Md</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4.2.1</u> <u>Acute myocardial infarction</u> <u>1 day</u>
DUE TO <u>1</u> <u>duration</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive & arteriosclerotic Cardiovascular</u> <u>Years</u>
DUE TO <u>2</u>
(c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebrovascular accident</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Feb 27, 1951</u> to <u>Jan 5, 1960</u> that I last saw the deceased alive on <u>Jan 5, 1960</u> , and that death occurred at <u>11:45</u> M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Faye W. Allen</u> M.D. | | ADDRESS (Street, city or town, state) <u>62 Cathedral St</u> DATE SIGNED <u>1/7/60</u> | |
| PHYSICIAN'S NAME (Type) <u>Faye W. Allen</u> | | Annap, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>1-10-1960</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Broadneck</u> | | 22d. LOCATION (City, town, or county) (State) <u>Skidmore Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William Keeseff</u> | | ADDRESS <u>Anna, Md</u> | |
| 24a. REC'D BY REGISTRAR <u>JAN 13 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



0208

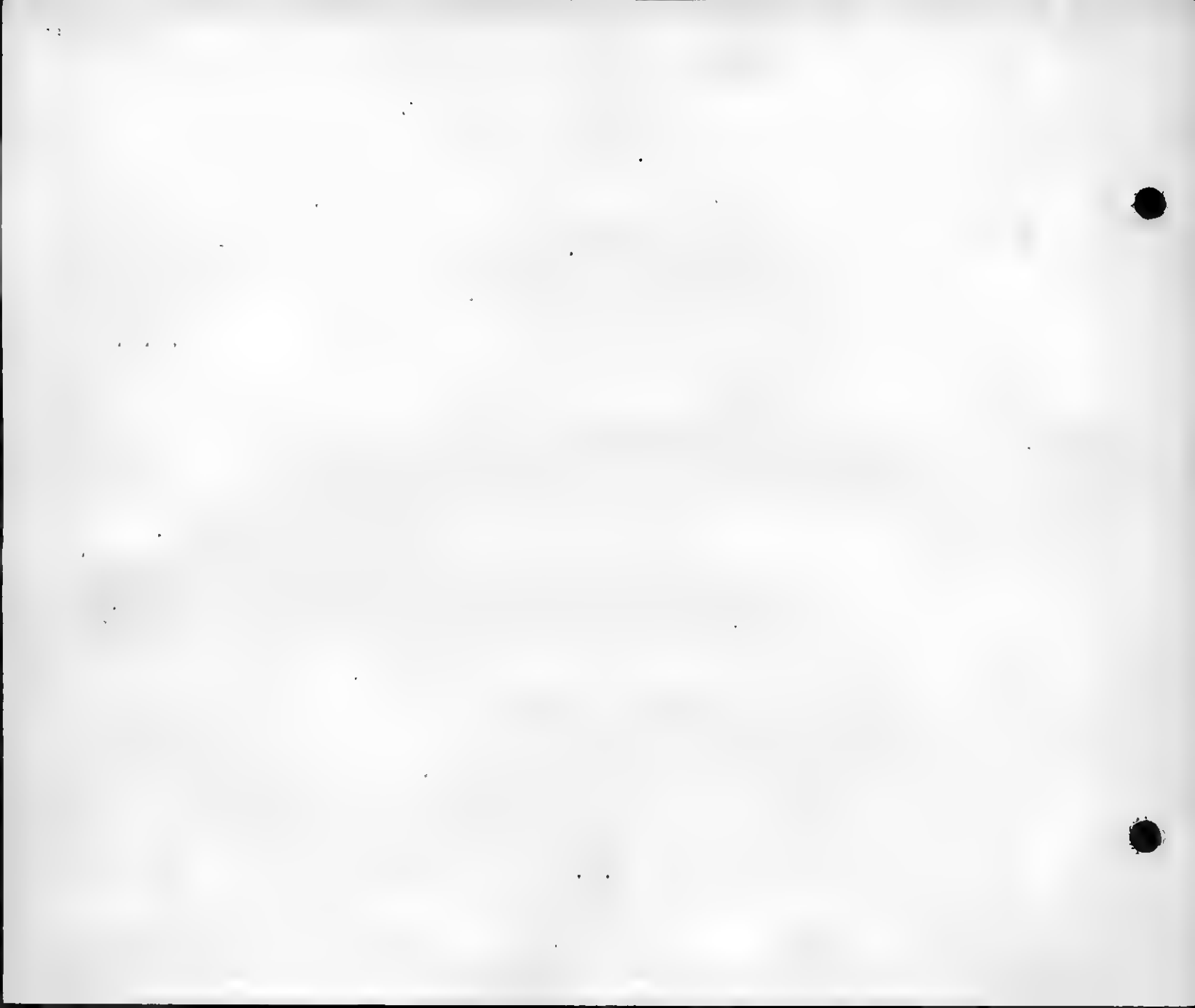
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|--|--|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Anne Arundel</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>✓</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Crownsville</u> | | c. LENGTH OF STAY IN 1b
<u>10.10 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Baltimore</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Crownsville State Hospital</u> | | | | d. STREET ADDRESS
<u>2620 Harlem Av.</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Walter</u> First <u>Willoughby</u> Middle Last | | | | 4. DATE OF DEATH <u>1</u> Month <u>13</u> Day <u>50</u> Year <u>19</u> | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>Negro</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>May 2, 1898</u> | 9. AGE (In years last birthday) yrs.
<u>61</u> | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Shipyard Worker</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<u>North Carolina</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Jordan Willoughby</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Hattie Stevenson</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>216-01-6276</u> | | 17. ADDRESS
<u>Hospital Records</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Uremia</u>
<u>442X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular R. & L. D's.</u>
DUE TO (c) <u>Old Cardiovascular Accident</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Hypostatic Pneumonia</u> | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>11/25</u> , 19 <u>59</u> , to <u>1/14</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1/13</u> , 19 <u>60</u> , and that death occurred at <u>10:00 P.M.</u> , from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <u>Crownsville State Hosp., Md 1/14/60</u> | | | | | | | |
| ACTUAL SIGNATURE <u>Walter Willoughby</u> | | | | DATE SIGNED <u>1/14/60</u> | | | |
| PHYSICIAN'S NAME (Type) <u>Lionel McHenry, M.D.</u> | | | | <u>Crownsville State Hosp.</u> <u>1/14/60</u> | | | |
| 22a. PLACE OF CREMATION OR REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town or county) (State) | |
| <u>Burial</u> | | <u>1/17/60</u> | | <u>St. John's Cem.</u> | | <u>Kingston N.C.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles W. W.</u> ADDRESS <u>512 E. ...</u> | | | | 24a. REC'D BY REGISTRAR
DATE <u>JAN 22 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Charles L. ...</u> | |

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



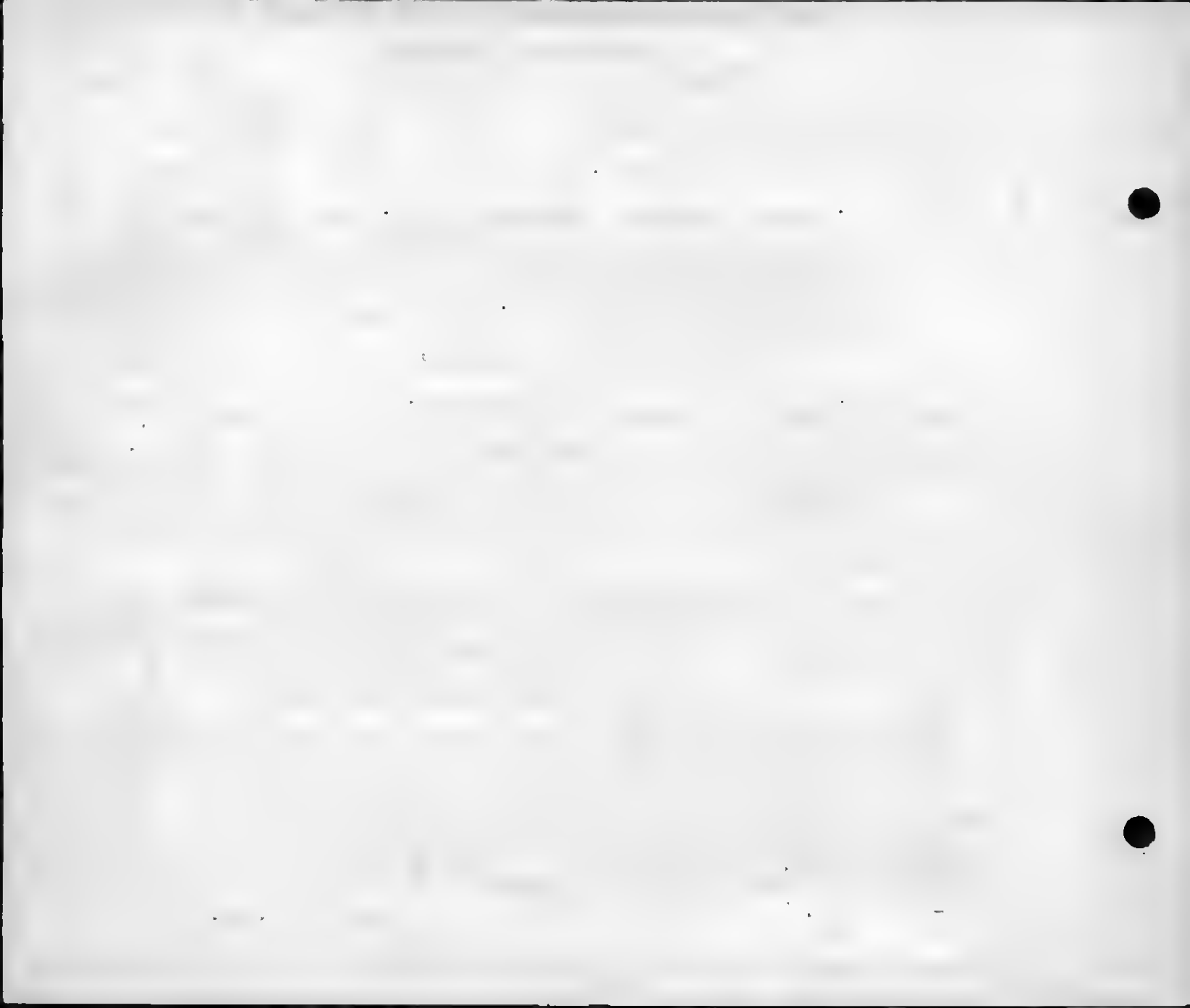
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
ANNE ARUNDEL | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
ANNAPOLIS | | c. LENGTH OF STAY IN 1b
1 Yr. | | 2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission)
a. STATE
Maryland | | b. COUNTY
Anne Arundel | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
LIDA MYRTLE WILSON | | 4. DATE OF DEATH
Month January Day 10 Year 1960 | | 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Dec. 21, 1875 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
House wife | | 10b. KIND OF BUSINESS OR INDUSTRY
own home | | 11. BIRTHPLACE (State or foreign country)
Dunbar, Pa | | 12. CITIZEN OF WHAT COUNTRY?
USA | | 9. AGE (in years last birthday)
84 yrs. | | IF UNDER 1 YEAR: Months 10 Days 19 Hours 60 Min. | |
| 13. FATHER'S NAME
Aaron R. Dearth | | | | 14. MOTHER'S MAIDEN NAME
Eliza J. Woodward | | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)
no | | | |
| 16. SOCIAL SECURITY NO.
? | | | | 17. INFORMANT
Harriet Dearth Wilson, 6 Dogwood Rd. Annapolis, Md. | | | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute coronary occlusion
DUE TO Coronary artery insufficiency
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery insufficiency
DUE TO (c) Coronary artery insufficiency | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | INTERVAL BETWEEN ONSET AND DEATH
3 minutes
5 days | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | 20c. TIME OF INJURY Month, Day, Year
Hour o. m. 19 p. m. | | | |
| 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from April 19 58 , to Jan 19 60 , that I last saw the deceased alive on Jan 10 19 60 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 121 Cathedral DATE SIGNED 1/10/60
ACTUAL SIGNATURE John L. Hedeman M.D. John L. Hedeman PHYSICIAN'S NAME (Type) John L. Hedeman MD Annapolis, Md | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Removal-Burial | | | | 22b. DATE THEREOF
Jan. 11, 1960 | | | | 22c. NAME OF CEMETERY OR CREMATORY
Highland Cemetery | | | |
| 22d. LOCATION (City, town, or county) (State)
California, Pa. | | | | 23. FUNERAL DIRECTOR'S SIGNATURE
HOPPING FUNERAL HOME | | | | ADDRESS
Annapolis, Maryland | | | |
| 24a. REC'D BY REGISTRAR
JAN 13 '60 | | | | 24b. REGISTRAR'S SIGNATURE
Arthur S. Thomas | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



| | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY
Anne Arundel | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Ft Geo G Meade | | c. LENGTH OF STAY IN 1b
26 hrs | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Distinct before admission)
a. STATE
Maryland | | b. COUNTY
--- | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
USA Hospital | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | d. STREET ADDRESS
1644 Warlick Ave | | 3. NAME OF DECEASED (Type or print)
First
WARREN | | Middle
G. | |
| Last
WOMACK | | 4. DATE OF DEATH
Month
January | | Day
23 | | Year
19 60 | | 5. SEX
Male | |
| 6. COLOR OR RACE
Negro | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
January 22, '60 | | 9. AGE (In years last birthday)
25 | | 10. IF UNDER 1 YEAR
Months
25 | |
| 11. IF UNDER 24 HRS.
Days
45 | | 12. IF UNDER 24 HRS.
Hours
45 | | 13. IF UNDER 24 HRS.
Min.
45 | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
--- | | 10b. KIND OF BUSINESS OR INDUSTRY
--- | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. FATHER'S NAME
Warren G Womack | | 14. MOTHER'S MAIDEN NAME
Jannie Murphy | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
--- | |
| 16. SOCIAL SECURITY NO.
--- | | INFORMANT
Mother (as above) | | Address
--- | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Prematurity | | INTERVAL BETWEEN ONSET AND DEATH
25 hrs | |
| 776X | | DUE TO | | (b) | | DUE TO | | 45 min. | |
| Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. | | (c) | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town)
--- | | (County)
--- | | (State)
--- | | 21. I certify that I attended the deceased from 23 Jan , 19 60 , to 19 , and that death occurred at 12:55 AM , from the causes and on the date stated above. | | DATE SIGNED
23 Jan 60 | |
| ACTUAL SIGNATURE
Matthew N. Harris | | M.D.
USA HOSP FT GEO G MEADE, MD | | PHYSICIAN'S NAME (Type)
MATTHEW N HARRIS, Capt., M.C. | | 22a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | 22b. DATE THEREOF
25 Jan '60 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Laboratory, U.S. Army Hospital, Fort Geo G. Meade, Md | | 22d. LOCATION (City, town, or county)
--- | | (State)
--- | | 23. FUNERAL DIRECTOR'S SIGNATURE
Betty M. Ellis, MSC | | 24a. REC'D BY REGISTRAR
JAN 27 '60 | |
| 24b. REGISTRAR'S SIGNATURE
Arthur L. Kraus | | 24c. REGISTRAR'S SIGNATURE
--- | | 24d. REGISTRAR'S SIGNATURE
--- | | 24e. REGISTRAR'S SIGNATURE
--- | | 24f. REGISTRAR'S SIGNATURE
--- | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
0210 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00208
Reg. Dist. No.

| | | | | | | |
|---|--|------------------------------------|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u> | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Same</u> b. COUNTY <u>Same</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Poolesville</u> | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Same</u> | | | |
| c. LENGTH OF STAY IN TB
<u>One month</u> | | | d. STREET ADDRESS
<u>151 Riviera Drive (Riviera)</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>151 Riviera Drive (Riviera)</u> | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) <u>Michael Daniel Zaucha</u> | | | 4. DATE OF DEATH
January the 5th. 19 60 | | | |
| 5. SEX
<u>M</u> | | | 6. COLOR OR RACE
<u>W</u> | | | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 8. DATE OF BIRTH
<u>10/25/59</u> | | | |
| 9. AGE (In years last birthday)
<u>2</u> yrs. | | | 10. IF UNDER 1 YEAR
Months <u>11</u> Days <u>1</u> Hours <u>1</u> Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>None</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>None</u> | | | |
| 11. BIRTHPLACE (State or foreign country)
<u>Baltimore, Md.</u> | | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | | |
| 13. FATHER'S NAME
<u>Carl Edward Zaucha</u> | | | 14. MOTHER'S MAIDEN NAME
<u>Marylin Sue Wood</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> (If yes, give war or dates of service) | | | 16. SOCIAL SECURITY NO.
<u>None</u> | | | |
| 17. INFORMANT
<u>Mr. C.E. Zaucha (father).</u> | | | Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory tract infection</u>
<u>527.2</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>?</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY
Hour _____ o. m. _____ p. m. _____
Month, Day, Year <u>19</u> | | | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | 20f. (City or town) _____ (County) _____ (State) _____ | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | | | | |
| ACTUAL SIGNATURE <u>Rustie H. Faubert</u> | | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u> | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1/5/60</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>1-7-60</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>GLEN HAVEN</u> | | |
| 22d. LOCATION (City, town, or county)
<u>A.A.CO., MD.</u> | | | | (State) | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Raymond J. ...</u> | | | ADDRESS
<u>4001 RITCHIE HWY.</u> | | | |
| 24a. REC'D BY REGISTRAR
<u>JAN 11 '60</u> | | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. ...</u> | | | |

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